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EXPERIMENTAL PATHOLOGY.

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Cats were used in these experiments, as dogs were not to be procured conveniently. For some reasons cats are more to be desired, but I prefer to use the latter. A litter of five healthy kittens was taken at about the age of two months, and under anesthetic lesions were produced on three of them by making a fixed point of one vetrebra and making pressure forward and to the side in the direction that the lesion is desired. The other two kittens were left normal, and were dissected for comparison. I was prevented from making as many experiments as I had planned, as the legislative matters in our state claimed my attention shortly after I began this work. Throughout this paper, I use the term *lesion* meaning a bony abnormality, such as was produced on these subjects.

Object.

The object of these experiments was, if possible, to arrive at some definite conclusion as to why a lesion of a single vertebra or structure will cause a variety of diseases, and why there is no certainty as to what the nature of the disease will be, or where or in what organ the disease may appear; and why lesions of several, various and remote vertebrae may produce the same identical disease. The anatomy is constant. The nervous and vascular mechanism is the same in all bodies, but we cannot predict with certainty, the result of any lesion. I know that it will require a vast number of experiments to arrive at any satisfactory conclusion on this point, but these have served as a beginning.

Nature of Lesions Produced.

The lesions were produced on the 5th of November and the animals, both the normal and those operated upon, were carefully observed. Dissections were made after four, five and six weeks. The subjects operated upon showed acute illness for several days. They were not sure of their walk. They were not playful like the other two and were not easily scared, nor did they care much for food. Number 2 seemed to be worse than the others, wobbled in its walk, and appeared weak below the middle dorsal. All three seemed to do better as time went on, but were never like the other two.

The Dissection.

In dissecting I noticed that these did not refuse the chloroform as the healthy animals did. I kept each animal alive under the anesthetic as long as possible so as to observe as much as I could during life and while the circulation con-

tinued. They all showed the same lesion, the tenth vertebra to the right and the tenth rib up. Possibly the bones were luxated a little more in Number 2. The same conditions were found about the lesion as Dr. McConnell has described in his several articles on Research. About the head of the rib there was an area of redness or inflammation which extended considerably into the adjacent tissues. The nerves about that point were red whereas normally they are white. The ligaments around the heads of the luxated ribs were lax (a condition that I was surprised to find.) Number 1 showed ecchymotic spots on the liver and the cardiac end of the stomach. While the intercostal nerve, the sympathetic ganglion, and the splanchnic nerve were all red and inflamed, this condition did not seem to have extended toward the chord. Number 2 showed a very large area of inflammation around the lesion. It extended to the ganglions above and below. In this case the inflammation of the nerves extended into the spinal cord and meninges and involved an area about an inch and a quarter long. The large end of the spleen was affected in this case, also the pyloric end of the stomach.

Microscopic Changes.

Miroscopic Examination showed a great congestion and much degeneration of the nerve tissue. The large end of the spleen was affected in this case. It was very hard, exceedingly dark in color, while the other end remained normal. Microscopic examination of the diseased end showed congestion (passive) and disintegration of the tissues. The stomach showed areas of inflammation around the pyloric end. Number 3 showed much less inflammation around the lesion, and it did not reach the cord. The stomach showed congested areas but in this case the intestines seemed to be the most affected and worms were found in great numbers. In all of these cases there was a general dilatation of all the abdominal vessels. This condition was a little more apparent in Number 3. Microscopic examination was made of all the diseased parts but they failed to show any pathological condition except the results of vaso-motor disturbances in the way of congestion, active and passive, and inflammation.

Effects of Lesions.

The degeneration was from the lack of free circulation and nourishment to the cell bodies. This seems, so far, to be the extent of the pathological conditions produced by lesion, congestion and inflammation, the result of vaso-motor inhibition, loss of function and sensation by lesion to the motor and sensory nerves. Other agencies and combinations of effects determine the variety and character of the disease. Dr. McConnell has well established the fact that inflammation arises from a nerve disturbed by lesion, and that it is the primary element in pathological conditions.

Reverse Peristalsis.

A few other observations were made, the most important of which was that if the intestine were firmly held between the fingers the peristaltic action of the gut would travel to the point held and would then reverse and travel backward.

Animals Number 4 and 5 showed none of the signs of disease found on Numbers 1, 2, and 3.

Nerve Action Under Stimulation and Inhibitation.

I will not take up the histology of the nerve, but it must be remembered that the nerve can receive impulses and be inhibited anywhere along its neuron, cell, dendrite, or end-plate. It is generally agreed among physiologists that mechanical pressure continually applied will inhibit the nerve and will not excite it to action, except as Mathews says that "pressure may stimulate at first." That an irritation, inflammation, or neuritis of a nerve may exist so that it may not

carry impulses; that when a nerve is stimulated or inhibited along its neuron the stimulation travels equally in both directions of the neuron. In animal Number 5 where I dissected out the nerves for a short distance so as to conveniently apply pressure, I found that if pressure were made on the nerve that the effect of the stimulus on the organ supplied by the nerve was in proportion to the pressure applied, and when a certain degree of pressure was reached the impulses failed to pass to the organ beyond; then on applying the stimulation to the nerve below the point of pressure, the impulse was of full strength. In stimulating from the cell end a nerve supplying several organs, the implses would travel to all organs receiving branches from the nerve, until the point of pressure was reached there the impulses ended. Very little pressure served to impede the impulse nor did it require much pressure to cut off the impulse entirely. I found the intercostal nerve to have the greatest resistance, the splanchnic next, and the pneumogastric least. Mathews states in the Medical Handbook of Medical Sciences "while there is no variation in the excitability of the same nerve, there is considerable variation between the motor nerves of the same animal,—thus the sciatic nerve of the frog is far more irritable than the brachial nerve to all kinds of stimuli, and the sympathetic fibers seem less excitable than the motor."

The Law of Nerve Action.

We may draw the conclusion from this statement and these experiments that the more excitable the nerve the stronger the pressure must be applied to impede the impulse. Again, if the nerves of a centre all have the same degree of receptivity for impulses, an incoming impulse would be deflected over every nerve connected with the centre. Pfluger's law seems to substantiate this idea.

Thus we draw from these experiments the conclusions that the fibers of one perineural division of a nerve have not the same power of receptivity for mechanical stimuli as the fibers of another perineural division of the same nerve trunk, and that the receptivity of one division does not always come within the scope of the other; and further that motor and sensory, secretory and nutrient nerves have a minimum and maximum degree of receptivity for impulses the same as the nerves of special sense. Of course many other experiments must be made to coordinate, and qualify these findings, but physiological, pathological and clinical evidence seems to warrant a definite channel of research along this line.

The Lesion and the Disease.

In osteopathic practice we have come in contact with practically all the diseases catalogued, and the correction of the lesions found have brought about a cure. It seems that where conditions are favorable, the lesions being corrected nature has full power over diseased parts, and that she is far more energetic in eliminating and discouraging disease than she is courageous in promoting it. So far, from these experiments, I am led to believe that the lesion, beyond its immediate effect in perverting the normal function of the nerves and arteries interfered with directly or indirectly, has nothing to do with determining the form the disease may assume.

The lesion produces the interference, be it sensory, motor, nutrient, or vaso-motor, and beyond this other agencies or combinations of conditions within or without the body determine the ultimate character of the disease. The lesion does not determine directly whether the disease shall be atrophy, tumor, cancer, ulcer, typhoid fever or mumps. Interference with a vaso-motor nerve can only disturb the normal duties of that nerve because it has no other functions but vaso-motion. Interference with a secretory nerve can only disturb the normal

secretion of that nerve because it has no other duty. Therefore I say that the lesion goes no farther than to pervert the function of the vital forces of the body. It is true that vaso-motor function is dependent upon nutrition, and that motion is dependent on sensation, and vice-versa. We noted in animal Number 2 that the spinal cord was congested and that degeneration had taken place on account of the blood not being properly supplied. We noted the same in the spleen. Thus we see that all the forces, in a measure depend on the others and if it is true that a certain degree of vaso-motor disturbance coupled with a number of degrees of disturbed neutrition will produce a definite form of disease, is a question of further research, but that the removal of the lesion will cure diseases in advanced pathological conditions, we do know.

Different Conditions follow the Same Lesion.

We note in these experiments and those of Dr. McConnell that like effects of the lesions are rarely found. These lesions were as similar as it was possible to make them. They were all at the same point, and the force applied was as near the same as I could gauge it, and I got liver trouble in one case, spinal trouble in another, and intestinal trouble in the third. It is so far impossible to tell when we produce a lesion what the effect will be and where it will manifest itself. It is even impossible when you know what nerve is interfered with to forecast where the effect will be manifested and if the nerve goes to more than one organ or its distribution widespread, the disease might not even manifest itself in the nerve interfered with, but pass beyond and show itself in some other organ or locality. We have always explained this condition by saying that the disease shows itself in the area of least resistance, and the explanation has so far seemed satisfactory and is doubtless true but the philosophy of the tract of least resistance is not yet well understood.

Hulett states in his Principles of Osteopathy that "the excess of energy will be distributed more or less over the entire nervous system, perhaps more to those offering least resistance, that is to those having the greater number of nerve strands," and further on "that in most cases some one or more organs will be found in the irritable state quite out of the odinary, and that the organ will be involved reflexly which is in the more irritable condition, and that the excess of irritability in one organ over that in another, will depend to a slight extent upon inherent capacity, but in a much greater part, upon a disturbed neutrition dependent upon an associated lesion." Now if the effect of the lesion always goes to the point of least resistance, as we have been always taught to understand it, we have not yet discovered the real and true primary factor in the cause of disease. It is well known that we have disease originating where there is normal vitality and that a lesion produces the disease. If not, why does the area of lowered vitality lie dormant until reinforced by the effects of the secondary disturbance to manifest itself as a diseased area? If an organ has a greater number of nerve fibres supplying it than another organ has the resistance of, that organ must be stronger as its ratio of fibers to another organ is greater. I think that if one structure has more nerves than another it is because of its size and function, and where one organ has a number of nerves supplying it each nerve has an area of that organ to supply and its duty does not overlap the duty of its neighbor; as an example, in the spleen of No. 2, in the liver of No. 1, and the ecchymotic patches on the stomach. We seldom find the whole organ involved, but usually parts of it or little patches of it; and if the nerve fibers be traced from a diseased area, say the fibers of the affected lobule and the fibers of the normal lobule, I think you will find that many of the fibers supplying the normal lobules will be in direct contact with the lesion.

Receptivity.

That the different organs of the body have different degrees of receptivity is well established by Byron Robinson in his work on the Abdominal Brain, and the fact that various drugs when taken into the body will have abundant effect on one organ and not materially disturb the rest of the system. The Reference Handbook of Medicine states "that the receiving organs at the extremities of the dendrites of the different classes of neurons differ widely in respect to structure and in their capacity to react to different stimuli and to transmit the state of excitation to the dendrites," and further it states "that the exciting organs at the extremities of the axones of different classes of neurons are of different types, and behave differently, the discharge of the exciting process upon a muscle, gland, or nerve cell being adjusted to the capacity for reaction possessed by the organ in question." I think the spleen is not capable of receiving the same amount or character of impulses as the liver, or the kidney the same as the stomach. I think that in the healthy body no organ by virtue of its size or nerve supply is any more susceptible or prone to disease than another. They retain their equilibrium until a nerve is affected and then that organ suffers whose receptivity best corresponds to the character and intensity of the lesion. We know that a nerve will respond more perfectly in action when a given degree of stimulus is reached than it will if the stimulus be regulated to a greater or less intensity. It has been demonstrated clinically and by these experiments that the intensity of the lesion is no rule to the extensiveness of the disease.

Theory of the Cause of Disease.

Hence the conclusion, that in the primary condition where a nerve supplies more than one organ or structure, each structure supplied has a different power of receptivity and resistance, and that the lesion to the nerve will affect that organ whose power of receptivity corresponds most actively with the degree of stimulation or inhibition exerted by the lesion; that this is the primary disease, and that the theory of area of lowered vitality does not become a factor until there is a secondary lesion; that the effect of secondary lesion will go to the area of least resistance or lowered vitality formerly produced by a lesion, I think there can be no doubt. Yet this may not always be the case and cannot by any means be made a rule. It is not held that these results are conclusive. I have only given the ideas that were suggested by these experiments after careful dissection and observation of the conditions that presented themselves; but I am satisfied that a great number of dissections and observations along these lines the great train of events between cause and ultimate effects can be systematized sufficiently to be of vast clinical importance.

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SALPINGITIS AND ITS TREATMENT.

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I have selected this subject as I am convinced that Gilliam is correct in stating "it is the most common of all diseases to which these structures are liable. Because of its frequency, tenacity, and the serious changes, both structural and functional which it entails, it is more productive of invalidism than any other of the diseases peculiar to the sex."

The Anatomy.

A few of the organs of the body seem not only by position but by form to be especially prone to disease. Among such are the Fallopian tubes. Passing out from both cornua of the uterus the tubes run almost horizontally to the uterine extremities of the ovaries where they turn upward close to the pelvic wall along the anterior margins of the ovaries to their tubal extremities. Here they turn downward, their fimbriated extremities embracing the posterior borders and inner surfaces of the ovaries.

The tubes are in reality attenuated continuations of the uterus, having an identical and continuous mucous membrane and peritoneal covering and a continuous layer of muscular tissue between these. The tubal lumen is least at the uterine end, being from 1-50 to 1-25 of an inch in diameter. In the ampulla, the most dilated portion of the tube, it is eight to ten times this diameter but narrows again at the peritoneal opening to from 2-25 to 3-25 of an inch. The tubal arteries are branches from the anastomotic trunk of the uterine and ovarian arteries, and likewise the veins empty through those of the uterus and ovaries. The tubal nerves are derived largely from the ovarian plexus but are closely associated with the uterine nerves. The lymphatics unite with those from the uterus and enter the lumbar glands.

As pathogenic predisposing peculiarities we would notice the tortuosities of the tubes and their naturally dilated middle portion. These favor poor intratubal circulation and drainage and invite sacculation of the normal or abnormal contents of the tubes with consequent bulging and weakening of their walls.

Again the situation of the tubes in a vascular sense, midway between the uterine and ovarian circulation, compels that they participate in all ovarian and uterine, and in fact in all pelvic circulatory changes. Being structurally continuous with the uterus they must participate in some degree, by continuity of tissue, in all pathological states of this organ. Thus the tubes may be said to possess no independence of their own, their structure, their circulation, their nerve supply, even their health being dependent upon that of other organs.

Cause and Nature of the Disease.

So also is it true that disease invades the tubes through other organs. All these conditions of whatever nature that cause pelvic congestion predispose to disease of the tubes equally as they do to disease of the other pelvic structures. Among these are muscular or osseous lower dorsal, lumbar, sacral, pelvic or innominate lesions. Heart, lung, liver or kidney diseases, abdominal constriction, tumors, displacements of uterus, ovaries or tubes, etc.

Being most intimately connected with the uterus, disease nearly always assails the tubes through this organ, so that the etiology of salpingitis is in the majority of instances that of the endometriits upon which it is dependent. Occasionaly salpingitis may come through lymphatic channels from the vagina or directly from primary involvment of the ovary or the peritoneum.

The great foe of the tubes is gonorrhoea, it causing according to various authors from fifty to ninety per cent. of tubal disease. We believe these estimates to bee too high. The gonococcus is found only in about twenty per cent. of tubal cases operated on, however the germ is short lived and may have been present in a greater per cent. of cases originally but has succumbed to unfavorable conditions.

Septic infection following labor at term, an abortion or a miscarriage perhaps ranks next as a cause of salpingitis. Cases arising from this cause are usually more severe and serious than those caused by gonorrhoea.

The gonococcus and the pyogenic germs invade the uterus and these cause

an endometritis and the greatest agency in causing an extension of the inflammation to the tubes is operative gynecology. I truly believe that the curette is more responsible for salpingitis than any other one agency. An endometritis exists and Nature is exerting every effort to combat it, but under the mistaken idea that the endometrium is entirely exfoliated at each menstrual period, the curette is used to scrape away the diseased endometrium and allow the growth of a new and healthy one. Even were this true the operation is attended with dangers and serious consequences. As the shedding of a small part of the endometrium in the form of epithelial cells is merely an incident and not the chief end of the menstrual period the folly of scraping, lacerating, tearing and destroying all that may remain of a healthy endometrium is at once apparent. However aseptic and thorough the operation may have been germs yet must lurk in the uterine glands, and for these the best possible culture ground has been made by the raw and denuded surfaces. An intense local inflammation results from the operation and in this the tubes necessarily participate. From this damage the uterus may and often does recover, but owing to their natural handicaps and peculiarities the tubes remain damaged and diseased. I do not deny that apparent improvement seems to sometimes follow a curettement but I believe this to be due rather to continued rest in the recumbent position than to the operation. It is a rare thing to find a patient who has been curetted who does not present positive evidences of tubal inflammation. It is my prophesy that in ten years the operation of curettage will have become obsolete and will have gone the way of many of the other barbarous treatments.

The use of the uterine sound is in a smaller measure responsible for the extension of an endometritis. Rough manipulations in examinations or treatment may so injure the tubes as to cause an inflammation.

Congestion from suppressed menstruation may be so intense as to result in inflammation.

Certain of the exanthemata are sometimes accompanied by salpingitis, particularly measles and scarlatina.

Classification of Forms.

Diseases of the tubes have the usual classification of acute and chronic, and into simple or catarrhal and purulent.

In simple or catarrhal salpingitis the mucous membrane of the tube is congested and thickened. The tube is slightly swollen and tender to the touch. It contains an increased amount of serous fluid. The inflammation does not usually extend through the tubal walls and involve the peritoneum. As a rule there are no adhesions formed about the tube. Complete resolution may now occur and the tube resume its natural function.

An acute catarrhal may become an acute purulent salpingitis but it more frequently becomes chronic. In this case the mucous membrane remains somewhat swollen and congested and the epitehlium destroyed in patches. The inflammation gradually extends to the deeper portions of the tube and it becomes thickened and enlarged. Should the peritoneal coat become involved as is often the case adhesions may form and cause the closure of the fimbriated extremity of the tube. When this occurs with an increased secretion of serum or mucous and the closure of the uterine end of the tube, it becomes distended, its walls become thinner and a hydrosalpinx of variable size will be formed.

In acute purulent salpingitis a much more severe grade of inflammation is manifested. The congestion is more intense and involves the deeper portions of the tube as well as the mucous membrane. The enlargement and tenderness are also more marked. The epithelium is destroyed early. The fimbriated extremity is usually closed from swelling, retraction and agglutination of the

fimbriae. This is a conservative step and protects the peritoneal cavity from the entrance of the septic contents of the tube. Pus collects in the tube and distends it. The entire tubal structure is affected and it is surrounded by peritoneal adhesions. These may later become organized and not only close the fimbriated opening of the tube, but constrict and distort and bind and mat it with the surrounding structures.

In the chronic purulent salpingitis the inflammation has become less acute but destructive and often permanent changes have occurred in the tubes. They are distorted, closed and enveloped in adhsions and filled with a purulent material. Their walls have become distended and thinned and the patient is in constant jeopardy from the possibility of rupture or leakage of this material into the peritoneal cavity. This material is actively septic at first but in time may become sterile. This is the so-called pus-tube. The resident germ is usually either the gonococcus or the streptococcus. Occasionally other germs are present. With the subsidence of the symptoms these germs gradually lose their virulence and in many cases so completely disappear that the contents of the pus-tubes are sterile.

Diagnosis.

The symptoms of an acute salpingitis are so closely identified with and overshadowed by those of the initial endometritis, ovaritis, etc., that the possibility of tubal involvement is easily overlooked. In addition to these symptoms a variable tenderness and pain above the middle of Poupart's ligament added to those of the primary trouble, is very suggestive. It is to the manifestations of the chronic stage to which we wish to call especial attention. Here we find pain and tenderness, heaviness, bearing down sensations, an inability to ride or walk in comfort, dysmenorrhoea, malaise, loss of flesh, pallor, weakness, indigestion, constipation, nervousness. The pain is variable. Is often colicky and burning in the iliac region of the affected side. May be dull and continuous or sharp and lancinating.

It is often paroxismal and is aggravated by lifting, walking, riding, coition, etc. Tenderness or pressure is usually present along the course of the tube. There is often a feeling of weight or heaviness if the patient lies on the side opposite the affected tub. The jolting or jarring of riding or walking is sometimes unbearable. The dismenorrhoea accompanying the trouble is peculiar in that it may begin several days before menstruation and last throughout the period. The pain is in the region of the ovaries.

After an indiscretion of any kind the symptoms are aggravated and there may be a rise of temperature. If both tubes are involved, sterility results.

A diagnosis is usually made from the history and a bimanual examination. An interview with the husband will enable you to judge whether or not gonorrhoea is causative. A history of sepsis following labor at term, a miscarriage or an abortion is very suggestive. The history of one or more curettments almost assures me that a bimanual examination will disclose diseased tubes.

Method of Examination.

A bimanual examination should always be made with extreme caution and gentleness. This is especially so in the acute stages, because of the great tenderness and because of the frail barrier of new adhesions, perhaps closing the tube and protecting the peritoneum from invasion.

Personally when pus is suspected, I do not advocate examinations under anesthesia, as I believe the patients expressed sense of pain to be the safest guarantee against violence and injury.

The more acute the case the greater will be found the tenderness. All parts palpated throught the vaults of the vagina may be exquisitely tender, but an exaggeration of this and a sense of fullness and resistance along the course of the tubes is very significant. After the acute symptoms have subsided, the enlarged tortuous and nodular tubes can usually be traced out from the uterine cornua.

Occasionally peritoneal adhesions have so matted together all the structures that the separate organs cannot be differentiated from each other by palpation, and all that can be determined is the presence of an ill-defined mass either to the side or back of the uterus. This with the foregoing history usually justifies a diagnosis of tubal inflammation. The pain and tenderness and consistence of such a mass combined with the rectal examination to definitely locate the uterus, will usually differentiate it from a uterine displacement or fibroid.

Prognosis.

In the catarrhal forms of salpingitis when resolution is not complete there is danger of a crippled and functionless tube and a consequent sterility. Should the catarrhal pass into the purulent form the likelihood of tubal destruction is more positively assured. Purulent salpingitis rarely causes death, yet there is lurking in every pus tube the possibility of death from the escape of its contents into the peritoneal cavity, either by rupture or by leakage through the unclosed fimbriated opening. Rupture has occurred spontaneously but is usually due to instrumental or bimanual examination, manipulation or some surgical operation about the uterus. A small amount of the contents leaking excites a local inflammation, with adhesive protection of the general cavity. Continuous suffering and chronic invalidism are by no means unusual. Ectopic-gestation is more likely to occur in a diseased tube and this fact must be considered in the prognosis.

It is not my intention to speak of the treatment of acute salpingitis further than to mention absolute rest in bed, enemata to keep the bowels open, light diet, ice bags at first over the affected area, thorough relaxation of the lower dorsal and lumbar regions, followed by inhibition, and a correction of lesions as far as possible. Later hot fomentations, hot douches and hot sitz baths will materially aid resolution.

In the chronic purulent cases the question arises, shall we dare violate the surgical law, "evacuate pus wherever found" and dare to treat a chronic purulent salpingitis by means other than the knife. Experience coupled with the statements of the surgeons themselves convinces me that we offer the majority of our patients the surest and easiest road to complete recovery.

The surgeons state that after a viriable time the germs lose their vitality and virulence and that the contents of most tubes are sterile. Should they not be, there is no reason why osteopathic treatment should not be administered with the most favorable result.

Treatment.

It is my rule after such a case has been examined and diagnosed, to explain the situation candidly and at length. Impress upon the patient that her co-operation in every detail is absolutely necessary. State that the time to do all that is possible for her will be measured in months and that her patience and persistence in taking the treatment will be essential. If the case is of recent occurrence and abdominal tenderness great, demand that she go to bed for a few days, perhaps a week or two. The alternative is an operation, which will keep her in bed much longer. This is an important part of the treatment, but one that is sometimes hard to enforce, as patients who are able to come out to your office will persist in staying up. Lesions in the cases, either primary or

secondary, are invariably found and should be removed as expeditiously as possible. These patients are usually poorly nourished, constipated, weak, nervous, often sleepless and general treatments are as a rule indicated. Besides the attention to the lesions, thorough but gentle treatment to the lower abdominal region is to be given. Treat as deeply into the pelvis as the tenderness will allow. Impress upon the patient that she must tell you when the treatment becomes uncomfortable, for here we have our best guide as to the severity of the treatment.

To place the patient in the knee-chest or Trendelenberg position or on her side will often enable you to reach deeper in the pelvis than in the dorsal position. After having given such treatment for two to four weeks, you will find the malaise, nervousness, nutrition and pelvic weight, heaviness and tenderness and general conditions much improved.

Local or bimanual treatments may now be begun. In giving these I prefer to have the patient in the dorsal position. Have the hands surgically clean, and begin by gentle bimanual manipulation of the tubes or tubal mass, the movements all being made towards the uterus. Remember to be gentle and let the severity of your treatment be governed by the pain caused. Let your rule be to do too little rather than to do harm. At the next treatment, question the patient carefully as to pelvic pain or discomfort, which may have been caused by the first treatment. Should any uncomfortable symptoms have resulted, be more gentle in your local treatment or defer it altogether at this time. If no symptoms followed the previous treatment, one as nearly like it as possible may now be given. Increase the thoroughness and length of the treatment gradually. Keep in mind that with each treatment you have something definite to do, a condition to overcome, circulation to stimulate, lesions to correct, for in truth these adhesions are such. After the local treatment is given and as a terminal part of it, place the patient prone and give gentle but strong inhibition to the lumbar and sacral regions. This tends to relieve any discomfort which may have been caused by the treatment.

If this course is persisted in for from eight to sixteen weeks a return of general health and often apparently healthy tubes will be evidenced by an absence of symptoms and by conception after years of sterility.

The diet should be governed closely. It should be light, nutritious and abundant. Hydropathic ministrations in the form of daily hot vaginal or rectal irrigations, hot packs and hot sitz baths offer valuable aids in treatment.

I do not contend that such treatment as this is applicable to every case, but it is applicable to that large number who are able to come for office treatment and do not show marked evidences of extension or active inflammation. There are cases active, progressive and virulent. In such, advise surgery. Also in those cases, none of which I have seen, who do not show early and positive improvement under the treatment I have outlined.

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PREVALENCE OF SACRO-ILIAC DISLOCATIONS.*

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Much has been said, still I feel that the sacro-iliac dislocations present to the osteopathic physician a large scope of development and discussion, if not the largest of any one part of the human framework, owing to the various effects produced by the slightest deviation from the normal of the structures forming this articulation.

During the last few years a large number of cases have come under my care in which the innominate bones were involved, and many and varied have been the so-called diseases that I have directly traced to this cause, and after corrections all former symptoms and effects have disappeared.

Cause of Prevalence.

The frequent occurrence of the sacro-iliac dislocation or slight strain, for often the deviation is so minute it could not always be classed as a dislocation, has brought to my mind the question, Why is there such a number of these cases, could it be that in different localities there would be an increase or decrease?

After considering this for some time, I have come to the conclusion that the mode of living and occupation with a rugged country probably presents a majority of these cases in the far West over those of the inhabitants of the East who live a more sedate life. People in the West often walk for miles over a mountainous road, not always being able to determine just how solid the footing for the steps to follow will be, and a mis-step will be taken, causing a terrible jar to the entire body, which is taken as such at the time and not thought of again, until several days or a month later, when pain is felt in hip, knee, toe, appendix, ovary or head. And after an osteopathic examination the cause is found to be at the sacro-iliac articulation, and after questioning, the pain, wherever it may be centered, is dated from time of such and such a trip over the mountains.

Again, at times one is compelled to walk through drifts of snow several feet deep and in taking these difficult slow walks, each foot stepping out of the snow has to be raised to a right angle with the body, so you can easily see the strain such stepping would bring on the muscles of the abdomen, pelvis and leg, increasing the abduction, adduction, flexion and extension to a great degree, and such walking for a day's time, bringing extra strain, weakens the muscles, causing the pelvic bones to be strained and the articulation pulled from its normal position. Also such as long rides in stage, buggy or on horseback over rough roads would be the beginning of trouble with this articulation, for rides of great distance are taken and not only is the jolting severe, but the sitting position is hard, lasting sometimes for ten or twelve hours, and the jumping in and out or off has been known to cause a dislocation.

While I have taken notice of these cases, I have observed that this dislocation or strain is more frequent in women but of more severity and more pronounced in men, which I think is due to the innominate bones of the woman being more easily strained as they are more delicate and less massive, while in a man it takes a more direct and forcible injury to dislocate these parts as they are broader and more compact, causing in turn a more complete dislocation and greater pain.

Anatomy of Articulation.

In discussing this articulation I wish to briefly give the bony frame work of which the parts consist. First, the sacrum, which is an excellent example of a wedge, is broad at the base and has a decided apex, and is the axis on which the innominate bones have their mobility, the upper half of each lateral surface, forms in front an auricular surface for this articulation.

The innominate bones, so named because they do not resemble any known object, are formed at puberty by the union of the ilium, ischium and pubes; they are large, irregularly shaped flat bones, with constricted center and expanded above and below. On the internal surface of the ilium and behind the iliac fossa is a rough surface, divided into an anterior and posterior portion. The anterior is of an auricular shape and articulates with a similar surface on

the side of the sacrum. The posterior has a rough surface for the posterior sacro-iliac ligaments and part of the erector spinae origin.

Taking the pelvic bones as a whole, they have muscular attachments of the abdomen, the perineum, pelvic floor and rotators of the thigh, and in addition, the ligaments of this especial joint, the sacro-iliac, are so well placed that they fortify the joint against abnormalities so that strains and wrenches of no mean proportion are necessary to alter the articulation.

Gray gives the sacro-iliac as an amphiarth-rodial joint, but Morris in his recent work, says: the sacro-iliac articulation is a diarthrodial joint. I consider this, an endorsement of one of osteopathy's greatest discoveries, namely, a joint of sufficient mobility to make malposition possible. From Cabot's latest work on Physical Diagnosis I take the following: "Goldthwaite has recently shown that the sacro-iliac joint is subject to most of the diseases of other joints, and that some are not at all uncommon here. Many of the pains in the back complained of by women during menstruation or in pelvic disorders are referred precisely to the sacro-iliac articulation and are probably due to lesions of that joint. Many cases diagnosed as 'Lumbago' are probably due to one or another sacro-iliac lesion. The subject is a new but very fruitful one." Here we have another endorsement of this old osteopathic subject—viz.: a joint in which causitive malpositions were discovered and corrected as early as our honored Dr. A. T. Still discovered other great osteopathic truths. The sacro-iliac dislocation and strains consist of forward and backward tilts. As it is so rare for an upward or downward dislocation to occur, on account of the wedge shape of the sacrum, I will not take it under discussion. In the cases I present, I wish to show how abnormal conditions of the sacro-iliac joint have been the direct cause of disturbing various centers and nerves, resulting in entirely different effects as the pressure may be. I also emphasize that improved effects and recovery are so marked, following successful correction of any abnormality of this joint, that I urge all to make a careful examination of the innominate and where trouble is found, do specific work, and the results are sure.

Cases Recited.

First, I call your attention to a case of a Mrs. H—, injured in a stooping position while hurriedly lifting. She felt something snap in her back, as she expressed it, and pain ensued almost immediately in the lower spine, while later she had continuous headaches and experienced a depressed nervous state. Patient went to bed for weeks, depending on the medical remedies, usually resorted to in baffling such cases, but was not relieved. When I examined her I found a decided sacro-iliac dislocation and a hypersensitive condition above and below the articulation. It was a forward position of the left posterior inferior spine of ilium. I have never observed an innominate case with more general nervous collapse. Hyperesthesia necessitated light relaxing treatment, confined to lower lumbar and sacral region. I kept the patient in bed much of the time and at the end of a month, finding the joint in improved tone, I set the innominate. It gave quick relief and from that date recovery was speedy. Discharged case at end of fifth week. No recurrence until this spring, four years later, caused by lifting, but was easily corrected.

The next case, a Mr. M., was a pronounced and interesting case of sacro-iliac dislocation. It resulted from a six or eight mile walk while prospecting in the Coeur d'Alene Mining District, Idaho. He walked with great difficulty over a rough country, through snow three feet deep, each step requiring labored effort. There was great fatigue, resulting no doubt in more irregular action in

joints and consequent greater strain. A day or so later he found himself unable to maintain an erect posture with the left leg extended. After a half dozen M. D.'s and Hot Lake sanitarium failed in curing, so-called sciatica, from which disease he had never been a sufferer, I discovered upon examination, a sacro-iliac dislocation, with forward tilt of innominate. Leg muscles were drawn and contracted. I placed the patient on crutches, (a procedure to lessen tension of the joint, I have found to be of much aid in certain innominate cases.) At the end of three weeks' treatment, confined wholly to the sacro-iliac region, relaxation was accomplished, and with Mrs. Moore's assistance reduction of the dislocation was performed. At the end of five weeks' treatment, a bright young man who had almost become reconciled to spending a cripple's life, was restored to health. In this case the only suffering was in the lower abdomen.

The next case, also a forward tilt of the innominate, was in a Mrs. M., passing through a nine year menopause, during which time constant flowing, in periods of weeks' standing was not unusual. As the result of a well-remembered fall down stairs, a period of constant flowing, covering eleven months was started. In a state of alarm osteopathic treatment was sought, I discovered right innominate forward. I at once corrected it, not treating case again for several weeks. Result was immediate, and now two years later patient reports, but two period seasons and both normal.

Apparently a similar position of the right innominate, produced in Mr. B., an acute attack of appendicitis after a previous day of mountain climbing, showing as it did the usual symptoms of such an attack. Examination revealed a forward position of the posterior inferior spine of ilium and a sensitive area there around. Patient had been subject to previous attacks but of less severe nature. I raised the caecum from its impacted position in the pelvis, corrected the innominate and on the third day patient was normal. Three years have elapsed and no return of the trouble.

The next case of forward tilt produced a cripple, a Mr. S—. The effect of injury was immediate upon lifting a heavy piece of lumber. He was confined in bed for a month during which time he was doped and treated according to the symptoms, his much deranged system indicated to a skilled M. D. Although a most decided sacro-iliac dislocation, it was diagnosed, a spinal curvature on account of the natural ability of the wonderful spine to compensate in position for a pronounced pelvic tilt. Even opiates would not relieve the distressed nerves which were calling for removal of pressure. Upon examination I found the left innominate was unmistakably tilted forward and the patient wholly unable to extend leg. It took a month to lessen contractions and increased leg motion, during which patient was kept in bed. The second month he was on crutches, and at the end of the month Mrs. Moore and I succeeded in reducing the dislocation. The patient experienced immediate relief and demonstrated for the first time his ability to maintain erect posture. Several weeks later he was discharged and has enjoyed his usual good health for the past three years.

The foregoing was one of the slow innominate cases, and now I wish to relate a case in which a patient was cured in one treatment.

A Mr. G— had been suffering for some weeks with what he considered rheumatism in the great toe of his left foot. It necessitated temporarily ceasing his work as railroad conductor. Upon examination I found a forward tilt of the innominate with slight sensitiveness at the sacro-iliac articulation. I at once corrected the slip, relief was immediate and there has been no return of the difficulty. That was two years ago. In this case the patient's trouble was in his toe, now I will call attention to one where the effect was in the knee.

A Mr. S— was thrown with horse seriously bruising the knee producing a synovitis. Entire left side of body was sore from fall, but apparently with all the difficulty in the knee. I discovered a sacro-iliac slip with innominate tilted backward. First I gave surgical attention to the knee and kept the patient in bed one week until activity was indicated. Then he was allowed the use of crutches for two weeks, at the end of which time all direct injury to the knee was overcome. Attention was then given to the innominate; patient was unable to completely extend leg when in erect position. With Mrs. Moore's assistance I corrected the trouble and instantly the use and comfort of the knee was secured.

The next, a case of ovaritis, was a Mrs. C— from out of town, who came for a six weeks' course of treatment. Her suffering was quite intense, a decided right sacro-iliac dislocation. The posterior inferior spine of ilium backward and a sensitive area, also sensitive along iliac crest. Eleventh and Twelfth ribs were dropped. I corrected the innominate at third or fourth treatment with immediate and steady improvement thereafter until recovery. No return in three years.

The next case, one of Amenorrhoea, was that of a sixteen year old girl, Miss W— apparently healthy in every way. She was late in becoming established. Had menstruated once and then lapsed for months. I found a backward tilt of innominate and no perceptible sensitiveness. Treated one month directing my work to correcting the sacro-iliac dislocation and menstruation was established. It has been two years and no further difficulty has been experienced.

One Unsuccessful.

Among the successful cases I wish to tell you of a failure. A Mr. O— had sacro-iliac dislocation, agreed upon between three osteopathic physicians in consultation, after carefully excluding hip dislocation. Three months' persistent treatment failed to correct. The patient became discouraged and will doubtless go through life a cripple, yet I feel that a year's treatment might have accomplished what three months' consecutive work failed to do. I consider it virtually a locked joint, held so, largely by the most intense contractions around an abnormal articulation. The case dated from a bad strain in a logging camp two years previous. It left the patient with a tilted pelvis. The posterior inferior spine of right ilium showed a decided backward position. The area of articulation was sensitive with more or less constant suffering in that locality. This is one of the very few cases of misplaced innominates that I have failed in. I do not believe that a year's practice will show more than one innominate failure, and I do not state that egotistically, but to emphasize that if we osteopaths develop ourselves in the skill of correcting innominate malpositions we are in a position to remove the real causative factor in many and varied diseases.

Case eleven, and the last one I shall give, was a Mrs. H—suffering from so-called chronic appendicitis due to horseback riding or possibly getting into or alighting from saddle. Being mountain ranchers forty miles off the railroad, there was much occasion for stage and horseback riding, a case in which the trouble could be charged to no other known cause. Suffering in the right iliac region more or less all the time, and aggravated after long rides, a state of anxiety existed that a surgical operation might have to be resorted to.

Examination revealed a backward tilt of the innominate. At second treatment it was corrected. No more suffering was experienced thereafter. Discharged case at end of a month. In this case, as in many others, we must bear in mind that sacro-iliac dislocations, especially if of long standing, require improved tone of ligaments, so that when an innominate is corrected the ligaments will fulfill their function of holding the articulation intact.

In conclusion I wish to state that it was not my purpose, and has not been my effort, to present to you a scientific article on the many complications of this subject, but rather to give you a practical talk on my own observations and experience in sacro-iliac abnormalities. I consider it a vital osteopathic truth that misplaced innominates do exist and that scientific osteopathic skill is necessary for their correction.

Sommer Building.

*Paper read before the eleventh annual meeting of American Osteopathic Association.

W. W. Steele, Buffalo, N. Y., then demonstrated a case of innominate adjustment with patient, as follows:

In this case the sacrum is forward and the innonminate back—the one on the left side mainly, the one on the right side does not seem to be disturbed. We find tension of the muscles and ligaments, forming quite a perceptible knot where they are thrown posterior. That produces pain around the crest of the ilium. Both legs are the same length. That does not indicate anything in the ilium. It is not a very good point to diagnose from. It is, however, a slight indication of the condition. My method of getting this relaxed is to put the knee against the right pelvis and put the hand on the left shoulder, pushing the patient back towards the median line, and up towards the head, and then by holding the pelvis in a fixed position with the fingers on the part to be corrected. By that movement you can often fix them. In this case it was corrected. I have a case now, a Mr. H., in reaching over for a bar he was standing on his right leg with his left leg off the ground, and when he straightened up he found he could not bring his leg down to the proper position, and great pain started. This same man took Christian Science for six weeks with no improvement, and his employer induced him to come to me, and I found a twist in the innominate. The innominate was anterior and the sacrum posterior, making the leg about two inches longer than the other. I treated him one month, but after the third treatment he resumed his work. At the present time it is not entirely corrected, but so near that you can hardly detect anything wrong.

C. B. Atzen: You say you never use the leg in diagnosing?

W. W. Steele: I use the leg to confirm my findings; not as a positive condition because I do not believe you can be positive of the position of an innominate by the length of the leg, because so often the shortening or lengthening of the leg is produced by the dislocation pressing on the nerve centers which control different muscles, and which sometimes produce lengthening or shortening of the parts according to what nerve center it controls or irritates.

Then another position is to get the person relaxed as much as possible, and then I place my hands on both sides of the sacrum, pushing apart each one of the innominates. And as you do that to bring the legs on a right angle with the body, and by pulling them apart in that way you very often correct the trouble I have just explained. Where you find an innominate posterior you put the patient on his back; draw him towards the foot of the table; bring his knees up in the position of an acute angle with his knees under your arms, so that you can use them as levers, and then bring your patient to one side of the table on the corner, and by placing the center of the spinous part of the sacrum on the center of the corner of the table make your downward pressure, and as you make that downward pressure have an assistant hold the patient, so that you can use the knees and make the desired pressure, bringing your weight on

the knees; and as you do that pull down with all your strength. That is another method I have in setting sacrums that are posterior where the innominates are anterior.

Another method which I consider very good for a dislocation of the innominate, and which of course throws the sacrum out of position, is to set the patient on a stool about 18 to 20 inches high; have an assistant in front of the patient and make a tension on the sacrum, and while he is in front, the position he should assume would be to get between the patient's legs so as to make him steady. You stand behind the patient and have the patient clasp his hands behind his neck, and put your hands under his arms, bring your hands around behind his hands, then having your patient relax as much as possible while you make a straight up pull, which relaxes all those parts; and when you make that pull have your assistant pull forward on the sacrum; and that method is used the same as you would pull out a wedge that is driven into a tree.

F. E. Moore: Dr. Steele states that he usually works alone. I am more fortunate in that Mrs. Moore usually assists me. This is a forward tilt of the innominate. I put my hand on the anterior superior spine, and take hold of the tuberosity of the ischium and with the other hand and make the motion do like that. (Demonstration) That is one I have found successful. And the reverse treatment is given where they are tilted the other way. Now I put my hand under the tuberosity of the ischium and push down on the tuberosity of the ischium and pull up on the posterior superior spine of the ilium, and draw the leg in and drop it out.

I have been asked if I had innominates that I could not keep in position after getting them in place, and in reply I will state that I have had quite a few.

C. E. Achorn: Do you find lumbar lesions, and if so do you correct the lumbar lesion and afterwards find that the innominate lesion continued?

F. E. Moore: I have found lumbar lesions, and my observation has been as you state.

C. E. Achorn: In lifting the tray of a trunk at one time I threw out the innominate. I could not secure a reduction of it until the next day. Now, whenever I step off of a car suddenly, or when I make a mis-step I experience severe pains across the sacrum, which does not seem to be well defined. It seems to radiate throughout my entire back and sacrum, and it is my present source of weakness.

W. W. Steele: In my practice it is usually the right innominate that is affected. Both of these cases before us are left. In this case the muscles are tense; the lower muscles are tight and swollen. The upper muscles are likewise swollen.

I am asked why I consider the right limb more often involved than the left? Simply because people get on and off street cars and railroad train, in fact in nearly everything they do they use the right leg more than they do the left.

I am asked if I had cases with an innominate lesion that I could not reduce? I will say that I have. I have reduced them under chloroform, but after a week they would slip out; I again reduced them, but finally had to give it up, it being impossible to hold them in place.

J. K. Schuster: In those cases did you get the lumbar muscles relaxed?

W. W. Steele: I had the lumbar muscles in good condition; the reduction was complete, and the patient was relieved of pain and suffering, but still it would not stay in place. Dr. Achorn says he has no pain in the legs, but the pain is chiefly across the innominate. In this condition he has a fifth lumbar slightly posterior, making a tension on the muscles, and they in turn pressing against the nerves, and that is one thing that helps aggravate the pain in his back; but the whole condition is produced by the innominate lesion.

THE INNOMINATE.

(Discussion in open parliment at the Eleventh Annual meeting of the A. O. A., Norfolk, Va.)

C. E. Achorn: We will now take up the Innominate, and I trust you will all take part in this open discussion.

C. B. Atzen: If it is agreeable I wish we could agree on the different points to be discussed. Let us take one point and make it a fixed point to talk from, either the movement of the innominate or the movement of the sacrum, so that we can follow the thought of the speaker; and let the speaker state just exactly what has moved forward, and what has moved backward.

H. W. Forbes: (with patient) I will attempt to tell you briefly what an innominate lesion is. When I say the innominate is anterior or posterior I want you to know exactly what I mean, and then if there are other conditions, or if any of you mean something else when you use the same terms we want to have you say so.

First, let us discuss the sacro-iliac articulation. The articular surfaces on the sacrum are directed outward, upward and backward. The sacrum does not fit down between the two innominates as the keystone of an arch, but just the reverse. The sacrum is wedged up between the two innominates.

The articular surfaces of the sacrum are wedge shaped. A line connecting the articular surfaces along the posterior surface of the sacrum is shorter than a line connecting the articular surfaces along the anterior surfaces. In other words, the sacrum is pushed upward and backward between the innominates in the form of a wedge. If all the muscular and ligamentous supports were taken away, the weight of the trunk would carry the top of the sacrum downward and forward between the two innominates. When the sacrum is pushed backward and upward it separates the innominates.

Now, let us examine this just one moment. A look at the skeleton will show that the formation of the articulation is such that the weight of the trunk tends to force the top of the sacrum forward. There must be some reason why the top of the sacrum does not tip forward, and that reason is to be found in the disposition of the ligaments about the joint. As the patient stands with the weight of his body transmitted to the top of the sacrum there is a tendency for the top of the sacrum to turn forward and downward, and for the lower extremity and coccyx to move backward and upward. The tendency of the sacrum to rotate on a transverse axis drawn through the center of the sacro-iliac articulation is counteracted by the great sacro-sciatic ligaments and posterior sacro-iliac ligaments. The great sacro-sciatic ligaments, which pass forward and outward from the side of the sacrum and coccyx to the tuberosity of the ischium are the chief factors in preventing the inferior extremity of the sacrum from moving backward and upward. Cut the great sacro-sciatic ligament on a cadaver and the inferior extremity of the sacrum may be moved backward and upward. With the sacro-sciatic ligaments intact slight forward and backward tilting may be produced.

The second important factor counteracting the tendency of the sacrum to rotate is the posterior sacro-iliac ligaments. The great sacro-sciatic ligaments prevent the inferior extremity of the sacrum moving backward and upward; the strong interosseus posterior sacro-iliac ligaments resist or prevent the top of the sacrum from moving downward and forward. (Patient stands on right leg). As he stands with the weight of the body on this foot the entire weight of the trunk on the right leg is borne by the right posterior sacro-iliac ligament. The normal movement of the sacrum on the innominates is a slight forward and backward tilt of the sacrum on the innominates on a transverse axis

passing thorugh the center of the articulation. The posterior superior spine of the ilium is directly behind the center of the joint. A line drawn horizontally from this, the axis of movement, is about on a level with the second sacral vertebra. In strong forward flexion the top of the sacrum moves forward and downward, the inferior extremity backward and upward, the great sacro-sciatic and posterior sacro-iliac ligaments are made taut; the posterior superior spinous processes come closely together, and the transverse diameter of the pelvis is lessened. In this condition the lumbar curve forward is accentuated. The increased pelvic inclination is an important factor in the causation of some cases of that attitude known as round shoulders. This condition might be named anterior sacrum, or bi-lateral posterior innominate. The former terminology seems preferable. In strong backward bending the top of the sacrum is carried slightly backward and upward, the inferior extremity forward and downward, the great sacro-sciatic ligaments are made lax, and the transverse diameter of the pelvis is slightly increased. In this condition the lumbar spine is more straight than normal. This may be named posterior sacrum or bi-lateral anterior innominate. The former seems the better. It is highly desirable that a uniform nomenclature be used, and the nature of this condition suggests that anterior and posterior sacrum be adopted as the names of lesions involving the movement of the sacrum equally, and in the same direction on both innominates. The term innominate lesion might well be limited to cases in which the lesion is unilateral.

I recognize two regular lesions of the innominate. By regular is meant a lesion predisposed to all the normal movements of the joint. A regular lesion inwards is one in which the innominate is retained permanently in a position of exaggerated normal movement. That may be named anterior innominate and posterior innominate. In anterior lesions of the innominate the anterior superior spine of the ilium is moved forward, outward and downward, the tuberosity of the ischium backward, upward and inward, the posterior superior spine slightly forward and slightly upward. The distance between the ensiform cartilege and the anterior superior spine is increased. The distance between the side of the sacrum and the tuberosity of the ischium is decreased. The great sacro-sciatic ligament is lax, the posterior sacro-iliac ligaments taut, sometimes torn. In a posterior innominate lesion the anterior superior spine is moved upward, backward and inward. The tuberosity of the ischium forward, outward and upward. The posterior superior spine backward, downward and inward. The distance between the ensiform cartilege and the anterior superior spine is lessened, and that between the side of the sacrum and the tuberosity of the ischium is increased. The great sacro-sciatic ligaments are taut and sometimes slightly torn.

The diagnosis of these lesions may be made by comparing the prominence of the posterior superior spines and by measurement. With the patient standing the posterior superior spine and the crest of the ilium if one inch forward from this point is less prominent than its fellow in anterior lesions, and more prominent in posterior lesions. In anterior lesions the distance from the ensiform cartilege or the top of the sternum to the anterior spine is increased, and that from the third sacral spine to the tuberosity of the ischium lessened. In posterior lesions the distance from any fixed point on the sternum to the anterior superior spine is lessened, and that from the third sacral spine to the tuberosity of the ischium increased. These bones are sufficiently positive to establish the diagnosis in most cases. Inasmuch however as these signs only indicate a difference in the two sides, one is sometimes in doubt as to whether one innominate is forward or the other backward. The presence of unilateral symptoms or effects may indicate the side of the lesion. In acute cases pain, tenderness and muscular rigidity are of diagnostic value. In case of doubt the

therapeutic test is available, namely, attempt to correct the asymmetry by working forward on one and backward on the other. The one, the seat of lesion will move under correct manipulation.

C. B. Atzen: What effect do innominate lesions have on the length of the legs, if any, in what way is the length changed, in anterior posterior lesions?

H. W. Forbes: The length of the leg is not greatly altered in either lesion. In anterior lesions the leg is apparently slightly longer, and in posterior lesions slightly shorter than its fellow. A line drawn from the anterior superior spine of the ilium to the internal malleolus will measure practically the same on the two sides. A line drawn from any fixed point on the sternum to the internal malleolus will be slightly longer than the normal in anterior lesions, and slightly shorter in posterior lesions. (Patient in dorsal position on table). If alteration in the length of the legs is used at all in diagnosis the change must be demonstrated by measurement from some fixed point on the trunk above the pelvis to the internal malleolus. To attempt a diagnosis by comparing the length of the legs as they are placed parallel on the table it seems to me is altogether unscientific, and this method is wholly untrustworthy. The reason for this is obvious. There are many conditions in which the pelvis as a whole is tilted up on one side and down on the other, and these cause great apparent lengthening and shortening of the legs. For instance, if the right leg is ankylosed in abduction, and brought parallel with its fellow by a tilting downward of the pelvis on the right side and upward on the left, it will be apparently much longer. This may be seen at a glance by comparing the malleoli and a measurement from the malleoli to the ensiform cartilege will show the amount of apparent lengthening. If on the other hand the right leg is immobilized in a position of abduction and carried parallel to its fellow by a tilting upward of the pelvis on the right and downward on the left it will be apparently much shorter than its fellow. In both these cases measurements of the actual lengths of the legs from the anterior superior spines to the internal malleoli show but slight difference. The leg which is apparently longer is actually slightly shorter than its fellow, and the leg that is apparently shorter is actually slightly longer. The reason for this is clear. Abduction lessens the distance between the anterior superior spine and the internal malleolus, and adduction increases it. Abduction lessens the distance because the axis of movement is on the hip joint. It is two to three inches below the anterior superior spine, and the distance between the anterior superior spine and the internal malleolus would continue to decrease in abduction until the leg was carried around to a point at which the anterior superior spine would be directly on a line between the axis of movement in the hip and the internal malleolus. At this point the distance between the anterior superior spine and the internal malleolus would be as much less than the length of the femur and tibia as the distance from the anterior superior spine to the acetabulum.

There are many affections of the hip joint which cause the leg to be held permanently in a position of abduction or deduction, and thus apparently lengthen or shorten the leg. Lateral curvature of the spine frequently produces a tilting of the pelvis as a whole, and thereby causes an apparent lengthening or shortening of the legs. Inasmuch as all of these conditions must be differentiated from innominate lesions, if apparent shortening and lengthening of the legs is used as a diagnostic point in these it seems wiser to rely upon the asymmetry previously discussed. In this connection we may remark that hip joint affections, sciatica, etc., which produce tilting of the pelvis as a whole, may be caused by primary lesions of the innominate; consequently innominate lesions should not be overlooked, because the apparent shortening or lengthening is otherwise satisfactorily accounted for.

I am asked why the leg is apparently longer in anterior lesions and shorter

in posterior ones? It is because the acetabulum is in front of the axis of rotation, and in anterior lesions the acetabulum is carried downward and backward, coming more under the sacro-iliac joint, and thereby the leg is apparently lengthened. In posterior lesions the acetabulum is carried forward and upward and the leg apparently shortened. Theoretically in an extreme anterior lesion the leg might be shortened if the acetabulum were carried behind the axis of movement. I have not actually met with such a case.

M. F. Hulett: Is the axis of rotation a shifting one?

H. W. Forbes: It apparently does not vary more than half an inch in regular lesions, being about on a level with the second sacral spine.

M. F. Hulett: What holds it?

H. W. Forbes: The chief structure is the strong interosseous sacro-iliac ligament. The great sacro-sciatic ligaments resist the tilting backward below and thus assist the posterior sacro-iliac ligaments in resisting the tilting forward and downward above. As a rule considerable force is required to produce a lesion when all the ligaments are intact.

W. E. Harris: I think the diagnostic rules are good except with regard to the matter of alteration of the length of the legs. The articulation may be made secure by passing something through the center of the joint, so that in the forward tipping of the innominate you can demonstrate the appreciable lengthening of the leg. You rather under-rate that point. In my class work I have demonstrated it over and over again. Putting the patient on the table and making a strong pull on the side you generally see what you want to, for you tip the pelvis as a whole; but I think it is a physical impossibility to have an innominate lesion without changing the length of the legs. Perhaps your other method of diagnosis is satisfactory, but it does seem to me that you overlook one of the oldest, that of changes in the length of the legs.

H. W. Forbes: There is undoubtedly a difference in the length of the legs in innominate lesions, the legs being apparently longer in anterior lesions and apparently shorter in posterior lesions. The chief objection I have to emphasizing this as a diagnostic point is that there are so many conditions in which the pelvis is tipped that must be differentiated in order to make this sign of any value.

Clara Wernicke: Does contraction of the gluteal muscles alter the length of the legs?

H. W. Forbes: Sustained contracture of the abductors will produce an apparent lengthening when the legs are brought parallel, and sustained contraction of the abductors will produce apparent shortening.

C. B. Atzen: Would sustained contraction of the adductors or abductors produce a tipping of the whole pelvis?

H. W. Forbes: With sustained contraction of the abductors the pelvis is tipped downward on the side by contraction, and the spine is curved toward that side when the legs are placed parallel, and the lumbar spine is curved toward that side. In sustained contraction of the adductors the pelvis is tipped up on that side and the lumbar spine curved to the opposite side.

A. G. Hildreth: While we are talking about innominate lesions and dislocations, there is one thing that is of vital importance to this association, and it is this: we find that so often in our practice a patient will come to us and say so and so said my right innominate was dislocated, or that this or that dislocation existed. That kind of talk to our patients is wrong, because it carries a wrong impression. The old school people ridicule the idea that we claim there can be a dislocation of the innominate and the sacrum. When it is actually dislocated we should say so. The common tilting of the pelvis anterior or posterior should be so called, and not called dislocated, because the thought of a dislocation in the mind of the average individual is a dislocated condition of an

articular surface, and that is wrong. We should say the pelvis is tilted anteriorly through an injury, a sprain, or contracted muscle, so they will clearly understand it, it will leave our profession in a much better position, and furthermore it conveys to them a correct opinion of their true condition. This is not only applicable to the sacrum, but to the vertebrae, the elbow, shoulder or any other part of the body. We should be careful what we say and how we say it.

C. E. Achorn: I am heartily in favor of Dr. Hildreth's idea. About a year and a half ago the medical profession in my city published a long article well illustrated proving the mobility of the innominate bone, and they said they spent two years demonstrating and proving the existence of that movable joint, with the result that they are treating what they call a movable pelvis. And we have one of our profession here today who knows through a friend that Dr. Goldthwait, the authority on orthopedics, admitted to an assembly, after first inquiring if there were reporters present, that he got that idea from the osteopaths. You can say that it has been demonstrated by the medical people beyond a doubt that this is a movable joint, and you can refer them to the article published by Dr. Goldthwait in the Boston Surgical and Medical Magazine; and you can further state to them that they stole our thunder.

A. G. Hildreth: I do not want to be misunderstood. There is no question but what we do have dislocated innominates, and there is no question but what we do have movable joints between the sacrum and the innominate, because it has been demonstrated time and again; but the point I make is, when there is a dislocation say so, and when it is only a tilting of the pelvis say so, and do not confuse the patient.

P. H. Woodall: I want to call your attention to an article published in a medical journal in Washington, D. C., about three months ago, in which a physician speaks of treating twenty consecutive cases of subluxated innominates. Down to where he refers to the treatment you would say he was an Osteopath rather than an M. D. He states among other things that these cases are frequently overlooked by the regulars. But in his treatment he relies largely on strapping the patient with adhesive plasters.

H. W. Forbes: In a recent book by Lovett on lateral curvature or scoliosis, he described the movement of the sacrum on the innominate, but I cannot entirely subscribe to the idea that it adds any force or weight to our theory of the movement of these lesions, because we can show some regular practitioner as an authority for our way.

E. M. Downing: I hold in my hand a letter from Dr. Goldthwait. Some weeks ago there appeared a statement in the papers to the effect that Dr. Goldthwait had read a paper before the medical association at Atlantic City, and the statement was made in it that he held that the sacro-iliac articulation is a true joint and subject to slips and displacement. I asked for a copy of the article and I have the doctor's reply. The New York Medical Record of June 15th contained the following:

"Boston, Aug. 22, 1907.

Mr. E. M. Downing, York, Pa.:

My Dear Sir: Your note in regard to the paper presented by me at the last meeting of the American Medical Association has been received. This article will appear within the next two weeks in the regular issue of the Journal of that Association. Trusting that this information is what you require, I remain,

Very truly yours,

JOEL E. GOLDTHWAIT."

I wanted to get it for the purpose of seeing whether the great orthopedic authority would give the Osteopath any credit for the discovery.

PROSTATITIS.

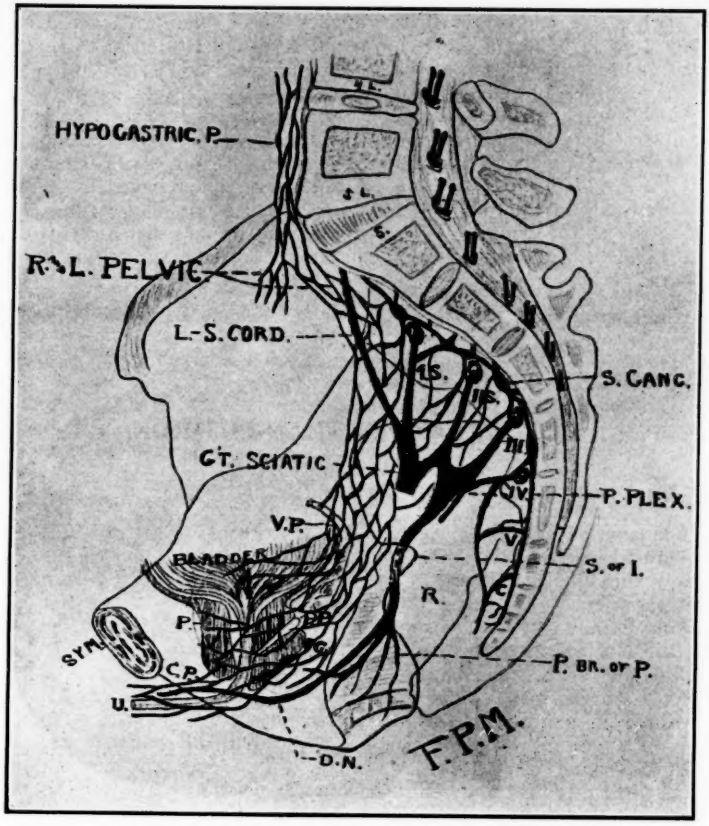
F. P. Millard, Toronto, Ont.

The word prostrate derives its name from its relation to the neck of the bladder, meaning, I stand. Its intra pelvic position protects it from outward injury. Normally the prostate is a sexual gland. Its secretion dilutes and coagulates the semen. In the congested condition not only is the normal function disturbed but the gland interferes with normal urination. This necessitates our considering the gland from a double standpoint,—sexual and urinary.

The prostate is largely composed of unstriped, muscular fibres and acts as an involuntary sphincter of the bladder, the urine from a distended bladder enters the pars prostatica urethrae, the portion of the urethra contained in the prostate gland and a strong desire to urinate is felt. Normally, relaxation of the compressor urethrae muscles occur, but abnormally, in the congested state, this muscle fails to relax and the prostatic muscle fibres contract and the urine is forced back into the bladder, influencing the urinary tract to a varied degree. Retention of the urine may bring on general toxemic symptoms, fevers following chills, and micturition and defecation become painful.

Prostatitis, or inflammation of the prostate gland, is usually distinguished from hypertrophy of the prostate, and may be acute or chronic, occurring in young and middle aged men, while hypertrophy or enlargement is usually restricted to men fifty years or over. Hypertrophy will not be discussed in this paper. In acute inflammation the prostate is congested, but in chronic prostatitis congestion may or may not exist. The amount of congestion can often be told by deep pressure over the bladder, which will be quite painful if congestion exists, and by noting whether the last drops of urine passed are blood tinged. Acute prostatitis is usually the result of the extension of an inflammation from adjacent tissues. The relation of the prostate to the bladder and urethra influences urinary affections, as the urinary stream is interfered with by any pathological lesion which increases the size of the prostate. Urinary symptoms can often be traced to prostatic origin and on the contrary inflammation of the prostate is always accompanied by urinary symptoms, local or general in nature. Infection traveling from the genital tract to the urinary tract or vice versa, must pass through the prostatic urethra which is one of the most important portions of the urinary tract. This local infection may lead to chronic prostatitis and possibly hypertrophy. However the constrictor urethrae muscle prevents, to a great extent, infections and inflammation from running back along the urethra.

Before considering the treatment for prostatitis, which is the primary object of the demonstration, we must review for a moment the innervation to the prostate. Indirectly, the gland is supplied from the hypogastric plexus, (see cut) more directly, from the prostatic plexus. But as lesion osteopaths we must trace all associated connections with the spinal nerves as well as visceral branches. The visceral branches are traced to the third, fourth and fifth S. (sacral) spinal nerves. These nerve fibres are closely connected with the sacral ganglia, as well as the visceral and prostatic plexuses. Coming from the second, third and fourth sacral we have the pudic plexus formation, and these nerve fibres are joined by the sympathetic branches not only at their formation, but near the termination of its branches by direct connection. Branches of the deep perineal nerve, (a branch of the pudic) sends filaments to mucous membrane of the urethra, also the dorsal nerve of the penis, (another branch of the pudic) which joins with the sympathetic branches of the cavernous plexus, (a direct continuation of the prostatic), making the prostate and urethra closely connected by nerves of spinal and sympathetic origin.



INNERVATION OF PROSTATE.

(F. P. MILLARD)

I's, II's, III's, IV's, V's, Sacral nerves; C. Coccygeal; P. PLEX., Pelvic Plexus; S. GANG., Sacral ganglia; S. OF I., Spine of Ischium; P. BR. OF P., Perineal branches of pudic nerve; D. N., Dorsal Nerve of penis SYM., Symphysis Pubes; V. P. Vesical Plexus; P., Prostate; P. P., Prostate Plexus; G., Ganglia found in prostatic plexus; R., Rectum; C P Cavernous plexus; U Urethra; 4L, 5L, Lumbar; S, Sacrum; C. Coccyx.

Examination and Treatment.

Unfortunately the middle lobe of the prostate is difficult to palpate by digital examination per rectum, and if prostate is highly congested even rectal examination is difficult on account of sensitiveness of the tissues. Perineal tenderness is often quite marked especially on deep pressure. The prostate lies one and one quarter inches above margin of the anus and the rectal face of the prostate will reveal the degree of congestion better than perineal palpation. Treatment per rectum should give way to extra-pelvic, if marked prostatic congestion exists, as irritation is liable to follow. After reducing the congestion in prostate by other methods, described below rectal massage over the gland will help to relieve the inflammation. I seldom treat per rectum. I prefer perineal, inguinal and pudic nerve treatment. Correcting all lesions as high, at least, as the micturition centre, including lumbo-sacral, innominate,

and cocygeal articulations, free the perineal circulation and then treat the pudic nerve. This nerve, and origin of its branches can be readily reached over spine of ischium, or as it lies in the ischio-rectal fossa, just internal to tuberischii. By flexion and circumduction of the leg the inguinal region may be treated and a more or less massage effect produced on the prostatic area, favoring venous flow. Cold sponge perineal baths are often beneficial, but hot Sitz baths are almost always harmful, as they induce a higher degree of congestion. However a hot rectal douche is sometimes beneficial, also hot supra-pubic applications. The circulation can be assisted and congestion relieved by evacuation of the bowels, stimulation of the liver to assist portal circulation, and strict attention to the entire urinary system. Acid urine, or any urinary disturbance, may aggravate a weakened prostatic condition. Regulation of diet will be of some value.

111 Confederation Life Bld.

MOTION RATHER THAN POSITION.

M. E. Clark, D. O., Indianapolis, Ind.

The explanation of the beneficial effects of osteopathic treatment, how they were obtained and why the lesions produced the disease, has undergone many changes within the last decade. The system has not changed,—it never will since it is a science—but many practitioners differ as to its application and explanation. Some so grossly misinterpret the significance of spinal lesions and make such extravagant statements as to what the treatments do and how they accomplish the results, that many intelligent people refuse to accept osteopathy as a science and confuse it (and rightly too) with massage, suggestion or other non-medical, unscientific methods of treatment. I deplore the methods used by many in exploiting osteopathy such as telling patients that they have a curvature of the spine when there is only a slight deviation; dislocation of a vertebra, when there is only a slight change of position possibly in the spinous process alone, and similar statements. The intention is probably all right but the effect on the patient, the patient's friends and especially on the family physician is such that they sometimes misjudge and make a laughing stock of osteopathy.

When I was a student, the subject of irregularity of the spinous processes was emphasized to a great extent. It was interesting to expose a patient's spine and note the position of the spinous processes, the examiner calling our attention to the fact that the second was to the left, the third to the right, the fifth anterior and the seventh posterior, etc., etc. I was greatly impressed with the importance of this method of examination but the significance of such has been overshadowed by other things of which I will speak later. I do not want to minimize the importance of examining the spines but rather *to emphasize the importance of examining the spinal joints. Lesions are in joints rather than in bones, that is the function of the joint should be considered rather than the position of the spinous process.*

The *function* of any spinal joint is *movement.* This movement is limited in any one joint but taking the combined movement of the spine, it amounts to considerable. The movement is restricted in degree by ligaments and muscles. Repeated stretching of these structures by carrying the movement to the limit, results in freer and a greater range of movement of the spine.

I have long contended that a *spinal lesion* is one in which the movement of the vertebral joints is impaired, either exaggerated or restricted. The degree of the lesion in a way, depends on the amount of impairment of the function of the joint, that is the movement. *Lesions of the vertebral joints are induced by carrying the movement of the joint beyond the point limited by the ligaments in their normal condition.* When the movement is carried beyond this point, something gives way, that is the ligaments are injured, this being followed by an attempted repair of the injury characterized by tenderness, swelling, limitation of movement, exudation and sometimes inflammation. In some of these cases there is an appreciable change in the position of the spinous process but in most of them there is not. If one were to depend on position, an error would be made in the majority of all cases. If one were to depend on motion of the joint, no error is possible since if the motion is normal, position must be. The converse is not always true, that is, if the position is normal, the function of the joint is not always so, on account of the inflammation and its effects; the results of the abuse of the function, i. e., motion.

Excessive movement is often of greater consequence than is restricted motion since it is more difficult to correct. *Any spinal or other affection characterized by relaxation is hard to cure.* Any joint affection characterized by excessive movement, that is relaxation, is extremely difficult to correct. Have you not treated cases of "willowy" spine?

The *indications of a spinal lesion* are then based on degree of impairment of the movement of the joint; condition of the adjacent tissues and position of the bone, but in reality the first includes all. If the movement of the articulation is normal, the condition of the adjacent tissues, that is the ligaments and muscles, must be normal. If the ligaments were sprained, then movement would be painful and restricted. If the motion of the joint is normal, then there must be good position, at least the change in position would not be appreciable. The articular surfaces must be in perfect alignment in order to insure perfect movement. From this we would reason that normal movement is indicative of a normal joint, while any change whatever in the movement of the joint from the normal is diagnostic of a lesion, the degree of change being indicative of the degree of the lesion. In making an examination for spinal lesions *I test the function* (movement) *of each individual spinal articulation.* In order to thoroughly understand this subject, one should be familiar with all the spinal joints, the amount of movement and directions of freest movement. I will not discuss this here for lack of space.

The *cause* of practically all spinal lesions is *trauma.* This may result in a hundred different ways. Anything that exaggerates the movement of any joint, especially if the exaggeration be sudden, is likely to injure that joint, thus constituting a lesion. This represents the type of lesion characterized by restricted movement. Systemic diseases produce relaxation of ligaments and if this so affects a spinal joint that the movement is exaggerated and especially if there is an accompanying tenderness of the ligaments, it constitutes a spinal lesion. This represents the opposite type.

Lesions of the spinal column produce *effects* through a lessening in size of the intervertebral foramina through which the nerve impulses to and from the spinal cord and brain pass. *This pressure is not due so much to a displacement of the bone as to inflammatory exudates deposited around the joint as a result of the primary injury producing the lesion.* It has been the popular belief that all bony lesions produce their effect through pressure of the displaced bone on the nerves and other adjacent structures. This idea is still held by many of the practitioners especially those that graduated from seven to ten years ago. I believe this to be the case in acute injuries, in fact I have reduced many a partial dislocation of a vertebra, but in the average chronic, I do not

believe it to be the case. Even if the vertebra is forced out of line, the least movement will assist in its restoration to a normal position if the injured tissues will permit. The conclusion then is that at the time of the primary injury the bone is displaced to some extent but in practically all cases except those followed by pressure or paralytic effects, the bone goes back into place and the effects are maintained by the injured tissues and not by pressure of the bone itself. There is an impaction, an approximation of the articular surfaces. This has given rise to many a mistake in diagnosis, *an irregular contour being mistaken for a lesion.* I know of a man, once prominent in the osteopathic profession who gave up osteopathy and stated that there was nothing new in the system because he was not capable or at least did not differentiate between an irregular spinous process and a real vertebral lesion. He said that he had faithfully treated case after case in which a vertebra was displaced to one side or the other (so diagnosed by himself and others in whom he had great confidence) and after a thorough trial had found that the bone was just as far out as it was when he began the treatment. He admitted that the patient improved under the treatment. The explanation lies in the fact that there was no lateral or other deviation in the position of the vertebra but an impacted, stiffened joint with adhesions all around the facets partly filling the intervertebral foramina.

In the opposite types of vertebral lesions, that is where the movements are exaggerated, little general spinal treatment is indicated; in fact I think it positively harmful in most cases. In those cases it has been my observation that there was one or two single lesions that alone should be treated, one or two spinal joints that were anchylosed or at least approximated and the treatment should be confined almost if not entirely to those joints. The location of this lesion is most frequent in the middle or upper dorsal area. The relaxed parts in themselves do not produce the effects that the single stiff joint does.

The principal *function* of the spinal column is to protect the spinal cord and its branches (nerves) in all natural positions of the body and to afford a safe channel for the nerve impulses that pass to and from the spinal cord. In order to fulfill this function, every joint must have its normal movement since if the movement of any joint is restricted, nerve impulses passing through the corresponding foramen or the blood carried to or from that particular part of the cord, would be obstructed, in which case the column is not protecting the channel of nerve impulses. If the intervertebral discs are thinned the function of the column would be impaired since the elasticity and movements would be restricted. Although there are other functions of the column this is the most important one and if there is normal movement in each joint, the movement as a whole will be normal and when this is the case, the principal function of the column is not impaired. It makes no difference what the contour of the spinous processes is, how crooked and irregular they are, just so the joints work right. Sometimes there is a deviation but this is the exception in most chronic cases. In other cases the irregularity of contour should suggest that there might be some affection of the joint, consequently the joint should be examined the closer.

The *object of the spinal treatment* so far as my practice is concerned, *is to get normal movement of the vertebral articulations.* As we artificially restore function (motion), the circulation through the joint improves, hence absorption of the exudate is increased. Just as soon as the exudates disappear, unless the facets are away out of alignment, the articular surfaces will go back into normal position without the use of much force and in most instances when the patient himself moves the part. Unless the muscles are too much contracted, it is a very easy matter to reduce a recent displacement (partial) of a vertebral joint if the case is seen soon after the injury. But little force is required. I don't

believe in using the force that some do and I think that the science has suffered much at the hands of those *that mistake force for skill.* This has given rise to the erroneous idea that osteopathy can be administered only to an athlete, that the weak are unable to bear the treatment, it being so rough and vigorous. In recent cases in which there is an appreciable displacement of a vertebra, I set it. In the chronic case I attempt to get movement at the affected joint and when I do, the lesion sets itself. I examine every joint in the spine when a patient comes to me for treatment and I treat only those joints that need it, that is those in which there is restricted movement. I have dissected many dozens of bodies in order to ascertain the pathology of the spinal lesion and I must confess that *it was the exception to find any appreciable displacement of the vertebra* even though the spines were irregular and the rule was to find the intervertebral foramina lessened by some sort of deposit or exudate.

In the "willowy" spine I advise physical exercises to strengthen the muscles that support the column and in addition the correction of whatever lesion that I find. It is there somewhere.

I am well aware of the fact that many osteopaths will think that I have departed from the orthodox bony lesion osteopathy, but I know that I haven't; that I am as firm a believer in the efficacy of osteopathic treatment as the most radical. I have only explained it in a way slightly different from that to which we are accustomed, but which we all practice every day: that is, treatment directed toward getting normal movement in all the joints of the body, especially the spinal articulations.

410 Board of Trade Bldg.

APPOINTMENT OF COMMITTEES.

President Moore announces the appointment of the following committees:

Transportation Committee: Dr. Alfred W. Young, Chicago, Ill., chairman, Dr. R. F. Graham, Batavia, N. Y., Dr. Jose C. Howell, Philadelphia, Pa., Dr. A. G. Hildreth, St. Louis, Mo., Dr. J. Erle Collier, Nashville, Tenn., Dr. Carl T. Samuels, Baker City, Oregon, Dr. R. D. Emery, Los Angeles, Ca.; Necrology Committee: Dr. Francis A. Cave, Boston, Mass., chairman, Dr. Florence A. Covey, Portland, Me., Dr. R. W. Bowling, Los Angeles, Cal.; Prize Essay Committee: Dr. E. C. Crow , Elkhart, Ind., chairman, Dr. A. H. Zealey, Goldsboro, N. C., Dr. E. D. Heist, Berlin, Ont.

These are for the most part "new blood" not having served on any committees in recent years.

It is hoped that the Prize Essay Committee will arrange with the Committee on Publication, Dr. S. A. Ellis, Chairman, for the conditions of the next contest so that these may be announced in the next issue of the Journal. There is evident interest in this contest as the editor has already had inquiries as to the specifications for articles to be entered for the contest. The prize, in addition to the honor and the contribution to the literature of the profession, is worth winning. The amount is fifty dollars.

THE AMERICAN OSTEOPATHIC ASSOCIATION AND WHAT IT STANDS FOR.

The American Osteopathic Association was formed just ten years ago, according to the seal, by early pioneers in the osteopathic profession for the mutual development and encouragement and for service to humanity.

Recognizing the old maxim that in unity there is strength, it has steadly grown in numbers as in every other particular.

A national association in any profession is a vital necessity to growth and preservation. Without it we are merely individuals carrying on our work in our own particular way in a personal field. By mere individual effort a profession cannot possibly grow or make its full value of worth felt in the world.

Concentrated endeavor is vital in these days of strife and development and a profession's greatest usefulness can only be obtained by such efforts.

Every man must realize that an exchange of thought with one interested in the same work and confronted by the same problems is essential to the mental growth of both. One cannot sit in his office pouring over his books alone, never seeing or talking with others as to these innumerable problems, and expect to develop. We will surely, by such routine, become mechanical automatons regardless of our personal ability and conscientiousness. Hence we need for our own very growth the profession's best association and broader thought.

An association of this kind means work and plenty of it for many, but the benefit to be derived should be shared by every one in the profession and the work therefore, should be a privilege. The literature alone, including Journal and Case Reports, is by far the best in the profession today, occupying a field peculiarly its own and representing the best in the osteopathic work in the diverse fields. A man is not doing himself justice when he deprives himself of these advantages.

The annual gathering is certainly a stimulation of the proper kind and a mighty aid for another twelve months of endeavor. It never fails to do me good to grasp a hand at this time, and to hear a sincere greeting of pleasure is certainly a privilege. All these things constitute life, for friendships are among its dearest possessions and we should not fail to renew them at every opportunity, for verily it is a privilege. Along with all this, if at one of these meetings a man cannot get more ideas than he has power to assimilate, it must be his own fault.

We realize furthermore, that all this requires effort, but everyone can contribute his mite and by doing so he will aid himself surely, and his profession also, and if all will do this we can become a mighty power in this wonderful age of growth when everything tends away from drugs and wants results in a rational way. Surely the returns for this little annual investment will compensate one an hundred fold.

If you can think otherwise as to the financial reward being honest with yourself, nevertheless, affiliate, because it is a part of your life work as an earnest, conscientious man, and let the returns take care of themselves.

ALFRED WHEELOCK YOUNG.

Chicago, Ill.

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NOVEMBER 1, 1907

MISDIRECTED EFFORT.

The transactions of the last A. O. A. convention made one issue paramount above all others, which is, that as an organization, we are at this time only willing to stand or fall in the defense of the fundamental theorems conceived and propounded by our venerable founder.

It is further (tacitly, at least) understood by all those who attended this convention that our proceedings be purely osteopathic, and that for the present we wish our progress to be measured by the "Osteopathic yard-stick" only. In taking this position, it is not, in my opinion, the intention of the Association to belittle or assign less than their importance to collateral sciences or arts, but rather, that the greatest gain can be made in Osteopathy by adhering strictly to and elaborating its fundamental precepts. It is not difficult to state this attitude of the Association:

One, the one Osteopathic theorem, that stands out sure, demonstrable, proven, regarding which there shall be no digression, no doubt, no equivocation, stated even so briefly, is that function is dependent on structure.

This is the great vital truth, that permits and withstands the white light of investigation, either along the lines of clinical evidence, anatomical, experience, or microspcopic research. In this, we are supreme and compelling in our certainty.

Whatever other methods constitute a part of Osteopathy, or whatever other methods constitute a part of the healing art, they are but mere by-ways compared to this broad and comprehensive road, so brilliantly conceived and laid out by A. T. Still. None others are so exact, so free from obstruction or confusion as this precept—function is dependent on structure.

It is upon this foundation that the entire superstructure of osteopathic pathology, diagnosis, and treatment, is built. It is this theorem that enables us to state our therapeusis in the one word, "Adjustment." Upon this truth we demand recognition; that as physicians we serve in a plane distinctly apart from all other schools of practice. These are facts, and as such, it does seem deplorable that we find it necessary to defend this fundamental fact to members of our own profession. It seems like a waste of time in unprofitable argument to make this defense, and our only excuse for so doing is in the hopes that the energy now being expended in misdirected effort can be conservated and added to a movement of concentration, the object of which is the development of pure osteopathy as originally conceived. If osteopaths are not sure of themselves, then osteopathy must be weak. *Not one of you will concede this.* That perverted structure is the cause of disease is the very foundation rock of osteopathy. It is the vital fact to which every one of our contentions are finally reduced. It is the one axiom that every osteopath must accept; hence, his line of action lies not in the direction of, "firing into his own ranks," but in giving his mind, his work, his undivided effort to the further development of this osteopathic truth.

Enough has already been written, based on scientific research, to permit the statement made above; that it is sure, "demonstrable, proven," but as a scientific proposition to be handed down, in all its fulfillment, it needs further elaboration. For the scientific members of our profession to concern themselves with problems outside of this premise is misdirected effort. We need them not to fight us but to aid in this elaboration. Retrospection of our growth is satisfactory. We have reached a numerical value that compels notice, makes us a factor in scientific proceedings; but we are moving too slowly in research work. Naturally, we find our evolution has been in epochs; theories have arisen, have stood, have fallen; this is as it should be, providing our growth takes place along lines of greatest eventual value to osteopathy. Among ourselves, we have been riven to the very depths, by discussion of certain theories, and these have not always been a part of pure osteopathy as originally conceived by our founder and yet, final threshings of all such departures has separated the grain from the chaff.

What is this grain? The everlasting, demonstrable, proven, vital truth,—"Function is dependent on structure," and the treatment is adjustment. It is the end reaction in the test tube, the last stroke of the dissector's knife, the final miscroscopic slide of the pathologist. *It is the cause of diseases, that is on the verge of being accepted by all the schools of practice.*

These words are only intended as a sane call to those members who are leaving the straight osteopathic road, stepping off into the by-ways of collateral sciences, which but diverts their efforts, rankles them with doubts, blinds them to beautiful theories and facts of osteopathy, which cry out for their aid in developing our science. A call to them; to concentrate their efforts towards elaborating osteopathic principles, as true and pure today as when we first accepted them.

As a protest to those who are attempting at this time to incorporate in our transactions other methods than osteopathy, not because such methods are lacking in virtue but because osteopathy does not need them; because, now of

all times, such digressions are misdirected efforts. As a warning to all of us, that other schools are continuing our investigations, deliberately plagarizing our scientific work, claiming originality for *our* theories and their proof. We cannot sit with folded hands and hope to retain our identity as a school. We have got to study, to work, to continue research, and thus fight for our rights. The cause of disease is a mathematical certainty; it only remains for us to solve its many, many equations. The world has produced one man who has for 30 years unflinchingly withstood the fire of investigation; has without a single digression stood within this one scientific fortification of function and structure, and yet every day it has grown stronger. Others have come to his aid, have helped him build but never has one atom of final value been added to his position, that lost sight of his fundamental precepts of cause and effect.

Are we in position, now of all times, just as our theories are about to be accepted by the scientific world, to misdirect our efforts? No! Let this year be devoted to the building up of the "old" osteopathy; let us cast out every thought antagonistic to the progress of osteopathy and devote our individual energies to its development.

Our work is but in its youth—we have grown so fast that like youth many of our scientific tenets are in awkward form. Let us round these out, give them grace and poise.

Let this be a year of individual effort, of individual research, so that when we go before the Old Doctor, next August, we can each place in his hands our well directed efforts, not one word or thought of which could be translated or construed into meaning anything but, *Osteopathy.*

H. F. GOETZ.

St. Louis, Mo.

The Journal with this issue presents the first of a series of Signed Editorials. It is believed that this will prove a very attractive and instructive feature. Much of experience and counsel may be given in an editorial way that would not be possible in an article of a different nature.

The excellent editorial of Dr. Goetz in this number will be followed by articles from Dr. Granberry and the other associate editors each presenting and developing a specific thought. The readers of the Journal are to be congratulated because of the cooperation that has been promised which assures a strong official organ to the profession.

Last year the association spent nearly two dollars per member on the Journal, which is about the limit that should be spent in this direction and do justice to other interests. This cost is based on fifteen hundred members. A membership of two thousand would give at the same ratio another thousand dollars to be put into the Journal, and the increased cost of the additional five hundred copies would be very small, and with this additional money, the value of the Journal to our members could be greatly increased.

There are yet outside of our membership at least one thousand practitioners, who would make good members and who would be made much better osteopaths for having membership in the association, and who would become members if approached in a personal way. Each reader of these lines has a friend or acquaintance among this class. The Journal makes an appeal to YOU, personally, reader, to send in the application of some one who needs this association. Let's have a revival of interest and a big increase in membership!

The movement to have a suitable painting made of Dr. Still should not be allowed to fail. It would be a rude shock now that the proposition has been made public for it to be abandoned for lack of support. The idea was happily conceived and the execution should not be allowed to languish or delay. This work must be done before August. The committee cannot assume the financial responsibility. The definite arrangements even cannot be made until the money is in hand. While this proposition properly came from the Alumni Association of the American School it is one in which all who wish to may unite and send to Dr. G. W. Riley any contribution for the fund. The Committee asked the A. S. O. graduates for $3.00 each.

Editor Fiske in the current issue of the Journal of Osteopathy speaking of the retiring of Dr. Evans from the editorship of the Journal of the A. O. A. says he has seen it grow from an "insignificant pamphlet to a journal commensurate with the profession it represents." This is all very nice as a sentiment, and nice for Dr. Evans perhaps, and may be it's the way such things usually start, but it was not the way the A. O. A. did. The first issue of the Journal was practically as large as this one. It was issued at first bi-monthly, but from the start the Journal was commensurate with the dignity of the profession, for the association did not think it was in keeping with the interests of the profession to issue as its official organ a mere insignificant pamphlet. It issued none until it was able to issue one that needed not to be apologized for. Dr. Evans has accomplished much for the profession through his work on the Journal, enough that is real, and he does not need and does not desire that misstatements be made for his benefit. It is taken that this statement of Dr. Fiske was entirely due to a desire to pay a compliment to Dr. Evans and no reflection on the association and notice is taken not for the purpose of picking up some inaccuracy in a contemporary but it is not just to the Association for it to go unnoticed.

Dr. A. T. Still seems to appreciate the wish of the profession to spend his eightieth birthday with him. In his Journal for October he has the following

very characteristic letter to the profession over his signature on the title page: To all Osteopaths who are Graduates of this, or any Other Regular School, who are tired of Drugs, Dope and Pills, Greeting: I want you all to come to Kirksville next summer and attend the A. O. A meeting here, and will promise to give you a good time and a full feast. We will save up the eggs of reason for many months in anticipation, and will see that none go away hungry. Bring your wives and husbands and knitting and have a Good Time. Yours, A. T. Still. A big meeting is inevitable. On all sides there are those who want to make this pilgrimage. In the year intervening let the profession bestir itself and purify itself of all that is not Osteopathy and be at the birthplace of Osteopathy a united, mighty throng. The suggestion is being considered of having August 6—the 80th anniversary of Dr. Still—a gala day in Kirksville. Arrange for a monster parade, barbecue or picnic, and let his old neighbors and friends of the town and country around have a part in doing honor to their neighbor and friend. Dr. Ellis guarantees a program such as our growing profession can furnish. The meeting will be all right. Let every member of the Association talk up this meeting and secure at least one new member to take to the meeting with him.

An Explanation.

The October number of the Journal suffered many mishaps. The stenographic report of the annual meeting did not reach it until the Journal should have been in the mails on its way to its readers, then in addition to the time required to get from the five hundred pages of report the matter needed for use, and the additional time required in a new printing office to entirely reset the magazine, advertisements, title pages, directory and all including the long official report and committee reports, the Journal was finally gotten into the mails October 12, and the fees deposited pending its acceptance for second class matter. The presumption was that this would have ended the delays, and it should but to cap the climax of this Tragedy of Accidents, the day the Journal reached the post office in Auburn, an order was received by it from the Department in Washington that every piece of mail matter should be counted, its amount of postage made a record of, and every thing be weighed. This was needed in making contracts with the railroads, etc., for carrying the mails and this condition continued for one week, and as late as October 20 in spite of additional help in the post office, about half of the number of copies still lay languishing in piles on the post office floor!

It is not the purpose of the management of the Journal to enter upon its duties with apologies—it hopes that it shall not need to—but this explanatory statement is due all concerned.

PARTNER WANTED—Lady osteopath, with large practice, in city of 300,000, wants gentleman partner. Must be a man of large experience, both professional and social. Address P. W., care of The Journal of American Osteopathic Association.

REMARKS BY DOCTOR A. G. HILDRETH AT OSTEOPATHY DAY CELEBRATION.

(The following report was taken by the official stenographer, but failed to reach the Journal in time for its proper place in the proceedings as publishd in the last issue. With this explanation these remarks are given place here.—The Editor).

This is the second of the great Expositions to honor us by setting apart a day known as Osteopathy Day. We should not be unmindful of this honor and courtesy extended us. This exposition is held to commemorate an historical event that has meant much not only to this state and this nation, or this continent, but also to this entire western hemisphere. It was the beginning of a civilization that has not been confined to this western world, but its influence and effect have been felt by the entire civilized globe; and we, as representatives of a new profession, even though we are few in numbers, represent an influence which is destined to be as far reaching, even as this event we celebrate for our work is destined to reach the intelligent people of all the earth.

It is useless for me to undertake to talk along lines I had intended to, because you are all familiar with what has been accomplished through legislative work for our profession in the United States; but if you will pardon me I will call your attention to just two or three little incidents that had to do in the beginning with our legislation and with the development and growth of the osteopathic profession.

The first that comes to my mind carries me back to a little frame structure in Kirksville, and I see there an old man that we all love and honor, Dr. A. T. Still. I called on him one beautiful Sabbath morning, long before the word osteopathy had been heard outside of the town of Kirksville. I had known him from my boyhood, and he said: "Arthur, come around here, I want to show you something. Most of you have seen a picture of his home as it was then, his first in Kirksville. He pulled down a dry goods box from the side of the wall, reached into it and pulled out a coffee sack full of human bones. He took from that sack bone after bone and articulated them, and there in his way told me what he was going to do for suffering humanity. It was beyond my comprehension. Even the name I could not remember, but in the light of the years from that day to this, I know, as you know, the truth that underlies the philosophy that originated in that wonderful mind, and has been given to the world through the association of the bones contained in the old coffee sack in the dry goods box behind that humble cottage.

Another incident that may be of interest to you: The first bill that was passed through any legislative body for the purpose of recognizing osteopathy was passed during the winter of 1895 in the Missouri Legislature, and Governor Stone of Missouri, now United States Senator, vetoed that bill. The reason I mention that fact is this: I, with many of our good, able friends, had labored hard and earnestly for the passage of the bill, that to have it vetoed was a shock to me I cannot express. I came home from Jefferson City after spending the winter there and working for the measure, thinking, of course, that it would be approved by the Governor—my experience with governors and their vetoing power was more limited then than it is now! After waiting ten or twelve days, a message came over the wire from Senator Seaber telling us that Governor Stone had vetoed the bill. My first thought was of Dr. Still. The first thing that flashed through my mind was that this act of Governor Stone would be a heart-stab to the man that I loved. I only tell you this to illustrate the kind of man he is. He was not at home. I watched for him, and saw him coming down the walk from the railroad, as spry

as a boy. He was then in his sixty-ninth year. I suspect I went to him with a rather doubtful expression on my face, for I was wondering how he would take the news. He looked at me and began to smile, and said: "Don't worry, boy; that was a poor law, and the next time we will get a better one." It has ever been that indomitable courage of his, that undying confidence that he has ever manifested in the profession that he has given to the world that is worthy of the example of every man and woman in this audience, and every osteopath that follows on down through all time to come. To his heroic, sturdy character, undaunted in seeming defeat, with his face ever to the front, always courageous, ever hopeful, and to his abiding faith that whatever is, is for the best, is osteopathy indebted for what it is today.

There was one other little incident I want to mention that may convey to your minds the kind of material he was anxious to enlist with him in this practice. I remember as well as if it were yesterday, it was in April, 1892, before he received his charter from the State of Missouri to establish the first school of its kind on earth, the American School of Osteopathy at Kirksville, Mo. I happened to meet him on the train, he came and sat down by me, and after talking a little he said: "Arthur, I want one hundred young men to study osteopathy. I want men that do not drink whiskey; I want men of good moral character; I want men that have the backbone to always stand up and be men." That was the description of the kind of material that he wanted to introduce into the profession that you represent today. I felt that I knew what he had in mind. I said: "The kind of young men you describe are very scarce and hard to find." We rode a little further and I said: "There is just one reason why I am not ready to say to you tomorrow that I will study osteopathy with you." He looked at me and asked what it was. My reply was: "I am afraid I can never learn to diagnose diseases as you do." He looked at me so intently, and replied: "I can teach you all I know." And I have found out since that he could do what he said.

Coming on down, there is another little matter that I would like to mention. Dr. Booth has spoken fiittingly of our growth, and of the principle that underlies our profession, and that we all know why we have succeeded. I wonder if any of you can imagine how I feel, and how those of the older men in the practice feel who know what the struggles were that we went through at Kirksville in the beginning of this practice, when we look over an audience like this, and realize what this profession that we worked so hard for then, has been to so many individual men and women. I often think of it. Your success and the good you are doing in the world are largely based upon the fundamental work of Dr. Still and others who labored so faithfully then under such adverse conditions. I want you to go back with me to Kirksville for just a few moments. Most of you know that I am a native of Adair County, Missouri, and when I speak of Adair county, I mean the county in which Kirksville is located, the birthplace of osteopathy. I was born and raised there, and as you all know, there have graduated from The American School of Osteopathy something over three thousand people. Well, one evening last winter a friend and I were discussing the number who had graduated, and who were originally Kirksville and Adair county people, and while talking we took one of our directories, and I went down page after page, and marked off the men and the women—the boys and the girls—that I had known in that county, who had graduated from that school, and upon counting them they totaled 465. I mention this fact for the reason that those men and women were men and women that I had known personally. I knew their opportunities in life, their advantages, under the old environments, and I know them as they are today. I wish you could know individually every one of those people as it has been my privilege to know them as they were then, and as they are now. I am proud of them and their record, and proud of my profession for it has given them the

opportunity to be what they are, and their success comes because they have earned it by aiding the sick with whom they have come in contact. They are here today representing, not Adair County and Kirksville, but as representative men and women in their chosen profession; they represent the greater number, if not all the states of this Union. The situation is this. You have entered this profession, you have demonstrated to the world your ability not only to make a success of your lives, but by the results you have obtained in your practice, you have proven the truth that underlies the profession that we are here to represent. That is a great satisfaction to me. What is true of the graduates of that school, and the men and women who have gone forth from Adair County, is equally true of the men and women who have gone forth from our other colleges.

Just recently a man passed through St. Louis who was born and raised in Adair County who has been in the field for eight years, and has been eminently successful. We were talking over the practice—and by the way he came to me at one time and wanted to know if I would advise him to study osteopathy. I said: "No sir; you have known osteopathy from its incipiency; you know what it is doing in the world, and unless you are man enough to make up your own mind and take up this study because you believe in it, and because you know that it is the line of work you yould like to follow, do not study it." I never advised him to take it up, but he did it just the same, and as I told you, he has been in the practice eight years. I said to him on his visit the other day: How about it, old man; are you satisfied with your profession, are you doing well enough to satisfy yourself, and is there all in it that you anticipated?" And he replied: "I never thought when I went into it that I could make the success that I have." I replied that it was not the financial success that I wanted to know about. "I don't care anything about what amount you have made, though I am glad you have been successful, but what I want you to tell me is, after spending eight years in the practice, if when you are called to the side of a bed where a patient lies hovering between life and death, do you know that you have the knowledge in your brain, the power in your fingers, and the ability to do all that can be done for that man or that woman by any school on earth?" He looked at me straight as he replied: "Doctor. I can do even more than the rest of them." That was a satisfaction to me, and what was still more gratifying to me was the thought that he had nothing in his office with which to treat people but his hands and his head.

We as osteopaths can point to the record of our past with a just and reasonable pride. The history of our growth, the success we have attained, the achievements that we have accomplished, should satisfy the most hungry heart; but, we must not let the successes of our past intoxicate us with the belief that there are no victories yet to win, nor battles yet to be fought; for as we turn our faces to the future, eager for the fray, we must realize that there are many problems yet to be solved. We must proceed with that judgment, with that deliberation, with that care, that will guarantee to the future generation yet unborn, that the principle given to the world by that grand old man shall never be snuffed out, but live forever. This Association, of which you represent a part here today, you men and you women, who have traveled, many of you across this continent, to uphold, means much to our profession as a whole. But, oh, I beg of you to remember that a baby must crawl before it can walk, and that a child must walk before it can run, and that though we have met with signal success we face grave problems; and it behooves every one of us to be careful, and to do only sensible things. We must have not only an abiding faith in the profession which we love, but a knowledge of its adequacy, and its ability to cure diseases. That is what has made us. I have always had the utmost confidence in the Guiding Power that has carried us to this point, and I believe and trust that God in his goodness and wisdom will guide us throughout all time to come. I thank you.

COLORADO.

The eighth semi-annual meeting of the Colorado Osteopathic Association was held in Denver recently, at the Brown Palace Hotel. In connection with all the papers read, a clinic was provided in order to demonstrate any new theory that came up in discussion of the treatment of the condition.

Dr. C. T. Samuels, of Baker City, Ore., gave a report of the A. O. A. meeting and also a talk on "Asthma and How to Cure it." He brought out the points most commonly and uncommonly found as causes for these conditions.

Saturday morning was given to general business of interest to the Association, which lasted until eleven o'clock. The rest of the time was given to clinic. At 12:30 the attention of the president, Dr. Mason, was called to a luncheon waiting down stairs. The meeting was adjourned to the dining room, where everyone present took an active part. The afternoon was given entirely to clinic, where fifteen cases were examined and discussed. Fifty-one per cent. of the osteopaths of the state were present at this meeting and five were out of the state at this time.

Respectfully,
R. A. ELLIS D. O.
Secretary.

Denver, Col.

MARYLAND.

The Maryland Osteopathic Association met Saturday, October 12, at Dr. Harrison McMain's offices on Dolphin street, and listened to addresses by Drs. William Pennock of the faculty of the Philadelphia College of Osteopathy on the spinal cord and its diseases, and by Dr. Aloha M. Kirkpatrick of Baltimore on typhoid fever.

The following officers were elected:

President, Dr. H. C. McMains, Baltimore; Vice-President, Dr. A. M. Smith, Hagerstown; Secretary-Treasurer, Dr. Grace McMains, Baltimore.

MASSACHUSETTS.

The Massachusetts Academy of Osteopathic Physicians began the ensuing year's work as a body on September 28, at the Parker House, Boston.

Dr. Frederick W. Sherburne, the president, gave an address which he called "A Plea for Honesty," dealing with some of the most pertinent topics of the osteopathic profession of today.

Dr. Sherburne has been requested by the Academy to publish his address.

GRACE B. TAPLIN,
Secretary.

NEW YORK.

The New York Society meets October 30 for an all day meeting. Besides routine business addresses will be made by Dr. Greenwood Ligon on "Sub-Tropical Diseases," and Dr. Charles Hazzard, "Osteopathic Diagnosis," and an address by the guest of the society, Dr. A. G. Hildreth, subject, "Osteopathy Written Indelibly With a Big O."

The Round Table, conducted by Dr. Elizabeth Fink, will consist of five minute talks on specific points of Gynecology, Obstetrics and Pediatrics.

It is also expected that former President of A. O. A. Ellis will be present and participate.

INDIANA.

The tenth annual meeting of the Indiana Osteopathic Society was held at the Dennison Hotel, Indianapolis, Indiana, Oct. 12, 1907.

"Back to Nature," was the president's watchword. Dr. Frank Spaunhurst cited a few instances where the best medical authorities are dropping the drug treatment and getting back to more natural methods of treatment. Dr. M. E.

Clark, of Indianapolis, emphasized the importance of an early diagnosis of tuberculosis, and is of the opininon that most cases can be cured in the incipient stage. Dr. J. E. P. Holland, of Bloomington, presented a paper on Visceral Splanch Noptosis, and Dr. Ella McNichol, of Indianapolis, on ear trouble. Practical demonstrations on how to correct cervical and dorsal lesions by Dr. Trufler, of Rensselaer.

We were very fortunate in having with us Dr. Charles Still, of Kirksville, who examined several clinic cases and also told about some of the pioneer work of his father, Dr. A. T. Still. He asked all to be present at the A. O. A. meeting at Kirksville next summer. Dr. A. T. Still will celebrate his 80th birthday, and the thirty-second year of the birth of osteopathy. A number of doctors from other states were present, besides Dr. Charles Still, of Kirksville, Mo., namely, Dr. H. M. Vastine, Pennsylvania; Dr. Evelyn Bush, Louisville, Ky.; Drs. Francis, Illinois and Drs. Trueblood, Michigan.

The following officers were elected:

President, Dr. E. C. Crow, Elkhart; Vice-President, Dr. J. H. Baughman, Connersville; Secretary, Dr. K. T. Vyverberg, LaFayette; Treasurer, Dr. Kate Williams, Indianapolis; Trustees, Dr. Lorena Schrock, Bedford, Dr. W. H. Johnson, Fort Wayne and Dr. George Tull, Indianapolis.

The entire programme was very interesting and instructive. The members not present missed a big treat.

K. T. VYVERBERG,
Secretary.

LaFayette, Oct. 12, 1907.

Dr. M. E. Clark, now practicing at Indianapolis, in a personal letter to the editor, makes the following interesting comments and observations on the meeting:

Dr. Charlie was with us and aside from diagnosing and demonstrating the treatment in many difficult cases, gave a talk on the early history of osteopathy and the experiences of himself and father during the pioneer stage of osteopathy. He said that none of us knew what a hard time was, when compared with what he and his father endured. He and the Old Doctor used to go from school house to school house and give talks and demonstrations. He said that he had asked his father to write up those early talks, since they would be of interest to many. This phase of the history of osteopathy was new to me and was received with interest by those present.

In the round table discussion adjuncts were treated and disposed of after quite a sharp debate. The subject of administering some opiate was debated. Dr. Baker described a case of spinal injury from falling slate, in which there was a fracture of the spinous processes of several of the middle dorsal vertebrae, with dislocation. The suffering was so intense that he called in a surgeon to administer an opiate. We all agreed that he did right. Dr. Holland recounted a case of renal calculi which he failed to relieve after working several hours. He administered an opiate to relieve that suffering, which was very intense. There was considerable discussion of this case, many stating that it was not a surgical case, hence an opiate was not indicated. I told them that there was a happy medium somewhere. Many of us are too radical. If the suffering causes more harm than the opiate, then I see no reason why the patient can not be relieved by means of the opiate, but I must confess that this is the exception, since I believe that the effects of the opiate are far worse than those of the pain, except in very unusual cases. There are times when an opiate is indicated, and when I meet such cases I ask the other fellow to do the administering. Some say that an osteopath should be able to do all. I believe that there is a place for everyone, and I don't care to spend years in a medical school just to obtain the privilege of giving an opiate in about one per cent. of my cases. It is a waste of time. Let the other fellow do it. The better the osteopath the less the use he has for drugs of any description. I don't care to know about drugs, since I would be tempted to administer them before I had exhausted all the osteopathic measures. The "Old Doctor" used to carry Dovers Powders with him before he perfected osteopathy, but after that he discarded them.

About fifty per cent. of the osteopaths of the state were in attendance. We pool our car fares here so that each pays the same. The purpose of this is to get a good attendance of those that are distant. We have all our meetings in Indianapolis, since all roads in Indiana lead to Indianapolis, and it is in the center of the state.

The state board is getting after the fakers and several are now under arrest.

DR. LOUDON MARRIES.

The Burlington, Vt., papers give a full report of the brilliant marriage of Dr. Harry M. Loudon and Miss Laura B. McKillip of that city, October 16, at 3:30 p. m. The best man was Dr. William Craig of Ogdensburg, N. Y., and Dr. Guy E. Loudon, brother of the groom, was one of the ushers. The marriage ceremony was followed by a reception which was largely attended by the society folk of the city. The gifts to the bride, some treasury notes of large denomination, silver, cut glass and gold plate, filled a room. Following the reception the newly wedded pair left for the West and will visit the groom's former home at Shenandoah, Iowa. Their home will continue to be in Burlington, Vt.

THE MEDICAL SOCIETY IN PENNSYLVANIA.

The annual meeting of the Pennsylvania Medical Society was in session recently at Reading. Although the society boasted of about 5,000 members it just quaked at the thought of a couple of hundred osteopaths being in the state and said many mean things about them. The allopaths in Pennsylvania seem to have great trouble in deciding what view they will hold of the osteopaths. Some of them want to treat the osteopaths as their equals, that is, demand that the osteopths be placed with them on the state board of medical examiners. Others say they are merely skilled masseurs and no more entitled to recognition than the masseurs or bath attendants are. Too bad the public thinks so differently, and almost every chance it has it does its part to dignify the osteopathic profession with just the same legal recognition it gives to the other schools. This has been the case with the two successive legislatures right there in Pennsylvania; and one governor vetoed it because it did not provide for a composite board and the next year, trying to please the governor, the Osteopathic Society put in a bill to meet the wishes of the former governor, and the present executive vetoed it because it should have been, in his eyes, the kind of bill his predecessor opposed. The governors down there seem to be as badly mixed as the medical society is.

But the point is this: The people for two years, through their members of the Legislature, have given the osteopathic profession the same recognition they give the older schools.

Dr. O. J. Snyder, president of the Osteopathic Society of the state, came out in very vigorous articles in several of the Philadelphia papers, which seem to have freely given him space, in which he very vehemently resents, in behalf of the profession of the state, the slurs made by some of the physicians. The osteopathic profession has entirely outgrown the position where such displays of temper effect the attitude of the public towards it.

THE PACIFIC COLLEGE.

The Pacific College of Osteopathy opened on the third of September with a fine class of new students. The prospects for the year seem exceedingly good, this is not only because of the number of new students, but also because of their character. It is becoming a matter of increased importance for colleges to carefully guard the character of students whom they receive.

REINSTATEMENT.

C. H. Grainger, Winston-Salem, N. C.
Geo. Betz Dresbach, Salinas, Cal.

RESOLUTIONS.

Whereas, In the Providence of an all kind heavenly Father, a worthy and greatly respected practitioner has been taken from the Indiana Osteopathic Society by the death of Dr. J. W. Cathcart, of Peru, Ind., and

Whereas, We shall miss his presence and influence in our meetings; his counsel and hearty co-operation from our work, and his tender sympathy from our fraternal ministries; be it

Resolved, That we deeply mourn the loss which results to our Society and to the osteopathic profession at large, occassioned by his death. Be it

Resolved, That we hold him in affectionate memory and acknowledge our gratitude to God for the noble qualities that formed his character, and the great interest he had at all times manifested in our beloved profession. Be it

Resolved, That we extend to the wife and near friends of our deceased brother assurance of our sincere sympathy in the time of their great sorrow. Be it further

Resolved, That copies of these resolutions be sent to the bereaved wife of our departed brother, and that they be sent to the osteopathic journals, and that they be spread upon our record for preservation.

C. L. NELSON,
J. A. CHAPMAN,
KATE WILLIAMS,
Committee

Indianapolis, Oct. 12, 1907.

REMOVALS.

Eva R. Wardell from 250 West 85th St. to The Ansonia, 73rd St. and Broadway, New York, N. Y.

Lula Ireland McKinney from Eureka Springs, Ark., to Garden City, Mo.

Orieannit Coppernoll from Kirksville, Mo., to Alliance, Neb.

Wilden P. Snare from Kirksville, Mo., to Alliance, Neb.

D. W. Coburn from Portland, Me., to 100 High St., Newburyport, Mass.

C. E. Abegglen from Pomeroy, Wash., to Ritzville, Wash.

Marie Torsen from Bixley Bld. to Long Beach, Cal.

J. D. DeShazer from Ouray to Durango, Col.

R. M. Echols from Kirksville, Mo., to Winston-Salem, N. C.

Ralph H. Burdick from Kirksville, Mo., to Tonopah, Neb.

Hester L. Beck, from 2159 Pacific Ave., to 220 San Jose Ave., Alameda, Cal.

W. E. Dressel from Alton to Rushville, Ill.

Joseph C. Goodsell from Webb Bld. to First National Bank Bld., Covina, Cal.

E. Anton Peterson from Mutual Life Bld. to Washington Bld., Seattle, Wash.

Wm. A. Potter from Safe Deposit Bld. to Washington Bld., Seattle, Wash.

Emilie L. Greene from 676 Woodward Ave. to Breitmeyer Bld, 24 Broadway, Detroit, Mich.

Jesse L. Hull from Weeping Water, Neb., to Avoca, Neb.

Bertha B. Southwarth from Kirksville, Mo., to 523 Harrison Ave., Leadville, Col.

Martha M. Foss from 38 Orton Pl. to 5 W. Oakwood Pl., Buffalo, N. Y.

Frances A. Howe from 38 Orton Pl. to 5 W. Oakwood Pl., Buffalo, N. Y.

G. T. Coffer from 279 York St. to 18 Britton St., Jersey City, N. J.

J. B. and Mrs. J. B. Littlejohn from 535 W. Monroe St. to 1906 Lexingston St., Chicago.

R. M. Crane from 220 W. 59th St. to 26 W. 25th St., New York City.

W. F. Harlan from Grand Forks, N. D., to Kirksville, Mo.

R. Annette Ploss from Witherspoon Bld. to Mint Arcade, Philadelphia, Pa.

Carrie M. Banks, Fairfield, Conn., name printed in last Directory, Bouks.

The names of P. L. and Rose Bathrick, 822½ Congress Ave., Austin, Tex., were omitted from the alphabetical list of the last Directory.

Wm. C. Classen, South Haven, instead of South Huron, Mich.

J. F. Holsclaw, Donephan, Mo., was left out of the last Directory.

APPLICATIONS FOR MEMBERSHIP.

Frank Heyer, 42 North Brady St., Du Bois, Pa.

C. J. Gaddis, Fort Collins, Col.

Evelyn R. Bush, 400 W. Breckenridge St., Louisville, Ky.

Jane Scott, 326 Mint Arcade, Philadelphia, Pa.

DENVER OSTEOPATHS.

The Denver osteopaths are perhaps doing the best thing they can to substitute for legal recognition. In the city papers under this caption, the names of those osteopaths entitled to recognition appear:

"Osteopathic physicians whose names and city addresses appear below form a complete list of graduates of reputable osteopathic colleges of Denver and have met all requirements entitling them to practice under the state law."

DEATH OF DR. CORBIN.

Dr. Margaret Agnew Corbin, wife of Dr. John Hauser Corbin of Westfield, N. J., died suddenly at the home of her father, at Fairchild Farm, Mt. Clemens, Michigan, October 10, of malignant diphtheria. Dr. and Mrs. Corbin had been spending the month of September at their summer home at Lake Orion, Michigan, and Dr. J. H. had only just returned home, to be followed in a few days by his wife and infant son, when the news of her death was received. The infant survived his mother.

MICHIGAN.

The Michigan State Osteopathic Association held its eighth annual convention at the Hotel Cadillac, Detroit, Saturday, October 19, with an attendance of sixty. The morning session was devoted to business. The afternoon session consisted of clinics furnished by Drs. E. A. Seelye of Coldwater, B. A. Bullock of Hastings, M. E. Garrett, W. W. Stewart, T. L. Herroder, Edythe Ashmore, of Detroit, and W. S. Mills of Ann Arbor, whose cases were discussed by Dr. William Smith of the A. S. O. The programme was very interesting and Dr. Smith conducted the demonstrations in a very able manner. The next place of meeting was decided to be Flint, and the officers elected for the coming year were: Drs. John M. Church, Detroit, president; B. A. Bullock, Hastings, vice-president; Betsy Hicks, Battle Creek, secretary; John Garrett, Ypsilanti, treasurer; Edythe Ashmore, Detroit, delegate to the A. O. A.; F. J. Harlan, Flint, chairman executive committee. A dinner at the hotel concluded the meeting.

OSTEOPATHIC SANITORIUM.

A company representing osteopathic interests has purchased the Senate Hotel at Atlantic City and have opened the Senate Hotel and Sanitorium, with Dr. O. J. Snyder physician-in-chief, and Dr. F. H. McCall, Resident Physician. The hotel, as such, had enjoyed a good patronage, and the sanitorium feature should be attractive. Atlantic City is one of the few resorts on the Atlantic coast that is open the year round, and the profession now has the opportunity to have their patients desiring or needing the conditions of the sea shore, offers good accommodations and osteopathic attention also, if it is needed, and at the end of the sojourn have the patient returned to their care without mind and body both poisoned against their physician and their school of practice.

Dr. Snyder continues his office practice at the Witherspoon Building, Philadelphia.

WEST VIRGINIA BOARD MEETS.

The Wheeling Telegraph says: "The State Board of Health has been called at the Waldo Hotel at Clarksburg for November 12, 13 and 14 for the purpose of examining applicants for license to practice osteopathy. It is understood there will be a number of applicants. A few years ago there was not an osteopathist in the state, and now there are one or more in every city of any size in West Virginia."

CAN'T SIGN IN WASHINGTON.

The profession in the state of Washington have had the Medical Examining Board get an opinion from the attorney general of the state as to the right of osteopaths as regards death certificates. The opinion is handed down that they have not the right to sign such certificates. This in no way interfers with their right to practice, as they are under an opinion from the state that their practice is not the practice of medicine as is contemplated by the law regulating the practice of medicine.

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